

FACE SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

RECEIVED FOR FILING

MAR 30 1961

Division of Administrative Procedure

ENDORSED

APPROVED FOR FILING
(GOV. CODE 11380.1)

MAR 30 1961

Division of Administrative Procedure

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Copy below is hereby certified to be a true and correct copy of regulations adopted, or amended, or an order of repeal by:

State Department of Social Welfare

(Agency)

Dated: March 29, 1961

By: *J. M. Nedemeyer*

Director

(Title)

FILED

In the office of the Secretary of State
of the State of California

MAR 30 1961

At 11:55 o'clock a.m.

FRANK M. JORDAN, Secretary of State

By: *Carter C. Tucker*

Assistant Secretary of State

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March 28, 1961

DEPARTMENT BULLETIN NO. 605 (BH)

TO: COUNTY WELFARE DEPARTMENTS

Subject: Central Registry of Boarding
Homes

In order to provide the public with one central source of information, each accredited licensing or inspecting agency shall maintain a central registry of all licensed homes within the jurisdiction of the agency.

The master file required to be maintained by the agency under Regulation BH-024.10 may be used or adapted for this purpose.

This information must be made accessible to the public.

This bulletin shall take effect immediately. An appropriate manual section will follow shortly.

These Regulations are designated to become effective April 1, 1961

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CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

FINDING OF EMERGENCY

Department Bulletin No. 605 (BH), Central Registry of Licensed Facilities, is an emergency measure for the immediate preservation of the public health, safety and general welfare within the meaning of the provisions of Section 11421(b) of the Government Code.

The following facts constitute the emergency:

1. In order to enable the public to select establishments best suited to the particular requirements of an individual in need of domiciliary care, current information concerning licensed boarding and foster homes must be readily available.
2. At present this information is not readily available to the general public throughout the state so that the best and most appropriate domiciliary care can not be selected.
3. Failure to effect the most suitable placement available will frequently damage the health, safety and general welfare of the persons requiring domiciliary care, and will thus be detrimental to the health, safety and general welfare of the people of this State.
4. This urgent problem is a current concern of the present session of the State Legislature which has urged the department to take immediate steps to remedy the situation and to eliminate, as far as possible, the threat to public health, safety and general welfare arising from the lack of readily available information on licensed foster and boarding homes.

It is therefore necessary that this Department Bulletin be adopted by the State Social Welfare Board as an emergency measure to take effect immediately.

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

FINDING OF EMERGENCY

The following Department Bulletin is an emergency measure necessary to the immediate preservation of the public health, safety and general welfare within the meaning of the provisions of Section 11421(b) of the Government Code:

Department Bulletin No. 597-A amending the effective date of Department Bulletin No. 597 presently effective on April 1, 1961.

The following facts constitute the emergency:

1. There was introduced on March 6, 1961, in the Senate of the State of California Senate Concurrent Resolution No. 35 whereby it was proposed that the Legislature resolve to request the State Department of Social Welfare and the State Social Welfare Board to revoke their authorization for complete annual physical examinations for Old Age Assistance recipients and to refrain from reinstating such authorization until such time as the Legislature has investigated the matter and signified its approval of such authorization.
2. On March 15, 1961, this resolution was sent to the Senate floor by the Senate Committee on Social Welfare.
3. The present April 1, 1961, effective date of Department Bulletin No. 597, is in direct conflict with Senate Concurrent Resolution No. 35 and therefore it is in the best interests of the immediate preservation of the general welfare to establish a later effective date so as to enable the State Legislature to express itself upon the subject.

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CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

EDMUND G. BROWN, GOVERNOR

STATE OF CALIFORNIA

DEPARTMENT OF SOCIAL WELFARE

J. M. WEDEMEYER, DIRECTOR

722 CAPITOL AVENUE, SACRAMENTO 14

March 28, 1961

DEPARTMENT BULLETIN NO. 597-A (MC)

TO: COUNTY WELFARE DEPARTMENTS
COUNTY AUDITORS
CALIFORNIA PHYSICIANS' SERVICE

Subject: Annual Health Evaluation for
OAS Recipients

Department Bulletin No. 597 issued January 31, 1961, pursuant to resolution of the State Social Welfare Board on January 26, 1961, is amended by changing the effective date from April 1, 1961, to July 1, 1961.

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These Regulations are designated to become effective April 1, 1961

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
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(Pursuant to Government Code Section 11380.1)

CERTIFICATE OF COMPLIANCE
Under Sec. 11422.1 Government Code

I hereby certify that prior to the adoption of the emergency regulations set forth below Sections 11423, 11424 and 11425 of the Government Code were complied with:

Repeal of A-206.2 filed with Secretary of State February 1, 1961
Repeal of B-206.2 filed with Secretary of State February 1, 1961
Department Bulletin No. 596 filed with Secretary of State Feb. 1, 1961
Department Bulletin No. 598 filed with Secretary of State Feb. 1, 1961
Department Bulletin No. 599 filed with Secretary of State Feb. 1, 1961
Department Bulletin No. 601 filed with Secretary of State Feb. 1, 1961
Department Bulletin No. 602 filed with Secretary of State Feb. 1, 1961
Department Bulletin No. 603 filed with Secretary of State Feb. 1, 1961
F-1000,A filed with Secretary of State February 1, 1961
F-1020,A filed with Secretary of State February 1, 1961

J. M. Wedemeyer
Director

**CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE**

(Pursuant to Government Code Section 11380.1)

Regulations

DELEGATION TO LOCAL AGENCIES

BH-014

BH-014 STANDARDS FOR ACCREDITATION

BH-014

In accepting accreditation, a local agency agrees to assume the following responsibilities:

1. To employ staff adequate in number and in competence to perform the duties required by this manual. For specific requirements, see Sec. BH-014.10 - 014.20.
2. To provide for staff assigned to the licensing program, qualified supervision and inservice training. See BH-014.30 - 014.40.
3. To establish procedures to determine the number and type of licensed homes needed in the county. See BH-014.50.
4. To develop a program to recruit homes in accordance with verified need. See BH-014.60.
5. To establish local procedures which insure that:
 - a. Preapplication interviews are available to potential applicants. See BH-104.10.
 - b. The licensing process conforms with the requirements of this manual. See BH-105 - 105.60.
 - c. Licenses are not issued to homes which cannot meet the standards set forth in this manual. See Standards for Boarding Homes for Aged (BH-110 - 115.50) and Standards for Boarding Homes for Children (BH-120 - 124.33).
 - d. Interim supervision of licensed homes (1) provides reasonable assurance of continuing conformity with standards and with the terms of current licenses and (2) helps licensees improve the quality of care provided. See BH-107 - 107.45.
 - e. Care not in conformity with standards is terminated in a prompt and consistent manner (i.e., through voluntary withdrawal or denial of applications; voluntary discontinuance of license or recommendation for revocation, and any steps necessary to initiate prosecution for operation without a license or an injunction proceeding). See applicable sections in chapter on Licensing Process.
 - f. Case records and statistical records are established and maintained, and reports completed in accordance with the requirements of this manual. See BH-020 - 025.

(Continued)

CALIFORNIA-SDSW-MANUAL-BH

Issue 01-9

Effective 7/1/61

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CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
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(Pursuant to Government Code Section 11380.1)

BH-014

DELEGATION TO LOCAL AGENCIES

Regulations

BH-014 (Continued)

BH-014

6. To supplement the supervision of licensed homes by providing other opportunities for licensees to increase their understanding of the needs of children and aged persons; learn effective methods of meeting these needs and receive recognition for the service they provide. See BH-014.70.
7. To establish and maintain a system through which homes licensed to provide 24-hour care for children are (a) allocated to designated child-placing agencies for their exclusive use or (b) earmarked for use by parents who elect to place their children without the services of an agency (i.e., independent boarding homes). See BH-014.80.
8. To establish and maintain a central vacancy file showing all licensed homes which can currently accept additional children or aged persons (i.e., all homes with vacancies except 24-hour BHCs allocated to child-placing agencies). See BH-024.11.
9. To provide an adequate service of counseling and referral for parents, aged persons, relatives of aged persons, and agency workers requesting information about available licensed homes. See BH-015.
10. To interpret to other staff, other agencies and the community, the licensing program, the needs of children and aged persons who require out-of-home care, and the proper use of licensed homes. See BH-015.10.

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CONTINUATION SHEET
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Regulations

DELEGATION TO LOCAL AGENCIES

BH-014.10

BH-014.10 STAFF - GENERAL REQUIREMENTS

BH-014.10

Each accredited agency shall have a staffing pattern which:

1. Assigns to one or more employees, responsibility for all phases of the licensing program described in this manual.
2. Insures that each employee assigned to any phase of the licensing programs will have sufficient time to perform his assigned duties in a competent manner.

There shall be review of the staffing pattern when a supervisor's duties exceed the supervision of more than six workers (exclusive of clerical staff).

If licensing responsibilities are assigned to professional staff who have other duties (i.e., intake for two or more programs; placement and supervision of foster children; public assistance, etc.), the workloads of these employees shall be limited to a size which permits performance of licensing duties in accordance with the requirements of this manual.

Sufficient clerical time shall be available to the licensing program to (a) conserve the time of social work staff; (b) insure the maintenance of adequate records and the completion of required reports and (c) make available the interpretive material needed.

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Issue 01-11

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BH-014.20

DELEGATION TO LOCAL AGENCIES

Regulations

BH-014.20 QUALIFICATIONS OF STAFF - LICENSING WORKERS

BH-014.20

Workers who receive licensing assignments after June 30, 1961, shall have the qualifications for their position title (or for a comparable title) as established in the class specifications for that title, adopted by the Social Welfare Board for the Merit System.

BH-014.25 QUALIFICATIONS OF STAFF - SUPERVISORS

BH-014.25

Supervisors assigned to any phase of the licensing program after June 30, 1961, shall have the qualifications for their position title as established in the class specifications for that title, adopted by the Social Welfare Board for the Merit System.

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Regulations

DELEGATION TO LOCAL AGENCIES

BH-014.30

BH-014.30 DUTIES OF STAFF - SUPERVISION

BH-014.30

The duties of a supervisor assigned to the licensing program shall include:

1. Developing or assisting in the development of a training and staff development program. (See BH-014.40.)
2. Periodic review of licensing records to determine the quality of practice and the areas in which further training is needed.
3. Supervision of the job performance of licensing staff by (a) helping individual workers acquire the knowledge and skill needed for performance of their duties and (b) providing assistance in formulating work plans and sound licensing decisions.
4. Maintaining effective case control to insure that licensing responsibilities are properly discharged.

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Issue 01-13

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**CONTINUATION SHEET
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BH-014.40

DELEGATION TO LOCAL AGENCIES

Regulations

BH-014.40 STAFF DEVELOPMENT

BH-014.40

Each accredited agency shall provide an orderly process of staff development for all employees assigned to the licensing program. This shall include:

1. Appropriate orientation to the licensing program, its philosophy and purposes, as well as to the duties of a licensing worker.
2. Inservice training designed to help staff acquire the knowledge and skill necessary to adequate performance of the licensing function.

BH-014.50 ASSESSMENT OF NEED FOR ADDITIONAL HOMES

BH-014.50

Each accredited agency shall establish systematic procedures for determining the community need for additional licensed homes, and the characteristics of the homes needed.

These procedures shall include:

1. A system of recording and compiling information about the characteristics of homes requested but not currently available (e.g., homes in certain geographical areas; homes able to accept more than three children of the same family; homes whose rates are compatible with OAS grants, etc.).
2. Periodic review of the vacancy file to identify the characteristics of homes not used to capacity over long periods of time.

Information about continuing vacancies is properly used to acquaint potential applicants, applicants and licensees with the current need for out-of-home care. It shall not be used as a basis for refusal to accept an application; for undue delay in the study of an application or for denial of an application. See BH-104.

Information about unmet needs shall be used as a basis for the agency recruitment program. It shall not be used to enforce an unwanted change in the terms of license, or a requested change which is not consistent with the best interest of children or aged persons requiring out-of-home care.

CALIFORNIA-SDSW-MANUAL-BH

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Regulations

DELEGATION TO LOCAL AGENCIES

BH-014.60

BH-014.60 RECRUITMENT OF NEEDED HOMES**BH-014.60**

An accredited agency shall accept responsibility for conducting an active recruitment program when it is evident that the current supply of homes subject to its licensing jurisdiction is not adequate to meet the needs of:

1. Parents, aged persons, or relatives of aged persons using its referral service.
2. Public agencies responsible for developing placement plans for children or aged persons (i.e., the county welfare department, the probation department or the CYA).

When additional homes are needed, an accredited agency shall make all reasonable efforts to (1) retain the interest of potential applicants who seem able to meet licensing requirements; (2) enlist the help of licensees in recruiting suitable relatives, friends and neighbors, and (3) inform the general public of the need for licensed homes (e.g., through speeches, news releases, T.V. and radio programs and/or announcements, etc.).

Licensing staff shall not invest time in any special efforts to recruit homes not subject to the licensing jurisdiction of an accredited agency. When appropriate, however, applicants and licensees shall be advised of (1) any existing need for homes subject to license by the SDPH or the SDMH and (2) any need for additional homes reported by a private child-placing agency licensed to approve foster homes for its exclusive use.

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Issue 01-15

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BH-014.70

DELEGATION TO LOCAL AGENCIES

Regulations

BH-014.70 RESPONSIBILITY FOR IMPROVING THE QUALITY OF CARE

BH-014.70

In addition to the interim supervision required by this manual (BH-107 - 107.45), an accredited agency shall develop a program designed to (1) improve the quality of care provided by current licensees and (2) sustain their interest in providing a continuing service for children or aged persons who require out-of-home care.

The program for licensees shall include appropriate methods to (1) interpret the needs of children or aged persons; (2) describe ways in which these needs can be met; (3) explain any changes in law, regulation, licensing procedures or staff and (4) convey appreciation of the services provided by licensees.

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Issue 01-16

Effective 7/1/61

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Regulations

DELEGATION TO LOCAL AGENCIES

BH-014.80

BH-014.80 CLASSIFICATION OF 24-HOUR BHC'S

BH-014.80

Each accredited agency shall endeavor to establish and maintain a system through which homes licensed to provide 24-hour care of children are (1) designated as agency foster homes for the exclusive use of a single child-placing agency (e.g., county welfare department, probation department, CYA, etc.), or (2) identified as independent boarding homes for use by parents who do not wish to use an agency placement service.

Any agency whose homes are not currently classified in this manner shall take immediate steps to classify (1) homes receiving an initial license (2) licensed homes not currently caring for children; (3) homes in which all children have been placed by their parents (i.e., independent boarding homes) and (4) homes in which all children have been placed by one agency. Other homes shall be classified as soon as this can be accomplished without replacing any children currently living in these homes. (For appropriate procedures, see "Specialized Services for Children" - p. 106-107.)

Agencies to which homes are allocated shall be requested to (1) provide an annual written evaluation of each foster home used during the preceding year (see BH-108.21) and (2) report immediately, any decision to discontinue use of an agency foster home.

Homes recruited by any child-placing agency shall be allocated for use by that agency, unless the licensee requests another classification.

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CALIFORNIA-SDSW-MANUAL- BH

Issue 01-17

Effective 7/1/61

CONTINUATION SHEET
R FILING ADMINISTRATIVE REGULATIONS
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BH-015

DELEGATION TO LOCAL AGENCIES

Regulations

BH-015 REFERRAL SERVICE

BH-015

An accredited agency shall provide a service of counseling and referral when a parent, aged person or relative of an aged person requests a list of licensed homes or help in developing a suitable plan for out-of-home care.

The service given shall include the following steps:

1. An interview (by telephone if necessary) to (a) obtain sufficient information about the child or aged person to determine his needs and (b) explore the possibility of developing another plan of care or of referral to another agency service (e.g., homemaker service, the child-placing service of this or another agency, etc.).
2. When indicated, review of the central vacancy file to identify homes which have some of the characteristics needed (e.g., location, rates charged, personal characteristics of the licensees, etc.) and
3. Review of licensing records to determine whether the homes selected for possible use would be likely to accept a child or aged person with the needs and characteristics described.
4. Discussion with the parent, aged person or relative about what it would be like for the child or aged person to live in the homes available and help in making decision about next steps.
5. If requested, referral to another worker or agency, or provision of a selected list of available homes (a minimum of three if possible).

If the interview indicates need for a facility not licensed by the accredited agency, a similar service shall be given whenever available resources are known (e.g., day nurseries, institutions for children or aged persons, nursing homes, homes licensed by the SDMH, etc.).

When appropriate, the steps listed above shall also be completed when a placement or public assistance worker, probation officer, or a worker from another agency requests assistance in finding a home that can meet the needs of a particular child or aged person.

On request, licensing staff shall participate in placement conferences to assist other staff in making decisions as to which of the homes available for use can best meet the needs of individual children.

CALIFORNIA-SDSW-MANUAL-BH

Issue 01-18

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Regulations

DELEGATION TO LOCAL AGENCIES

BH-015.10

BH-015.10 INTERPRETATION OF LICENSING PROGRAM

BH-015.10

All accredited agencies shall provide appropriate interpretation of the licensing laws, the procedures used in licensing and the meaning of out-of-home care to children and aged persons, to all members of the agency staff and to other community agencies or officials who have any direct connection with this program (e.g., officials responsible for enforcement of state laws or local ordinances which may affect licensed homes (zoning commission, health department, fire safety officials, etc.); the probation department, juvenile court judge, district or city attorney; mental hygiene clinics, hospitals, other social agencies, etc.).

Accredited agencies shall also utilize available opportunities to (1) increase general community understanding of the licensing program, its objectives, and the proper use of licensed homes and (2) stimulate the interest of community groups in meeting the needs of children and aged persons living in licensed homes (e.g., the need of aged persons for recreation and social contacts, of foster children for acceptance at school and in community activities, etc.).

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CALIFORNIA-SDSW-MANUAL-BH

Issue 01-19

Issued 7/1/61

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RECEIVED FOR FILING

APR 27 1961

Division of Administrative Procedure

ENDORSED

APPROVED FOR FILING
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APR 27 1961

Division of Administrative Procedure

Copy below is hereby certified to be a true and correct copy of regulations adopted, or amended, or an order of repeal by:

State Department of Social Welfare

(Agency)

Dated: April 25, 1961

By:

Director

(Title)

FILED

In the office of the Secretary of State
of the State of California

APR 27 1961

At 10:10 o'clock 9 M.

FRANK M. JORDAN, Secretary of State

By

Assistant Secretary of State

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BH-1.10 BOARDING HOMES FOR AGED PERSONS

BH-1.10

Boarding homes for aged (BHA) are of two types as defined by Secs. BH-1.11 and BH-1.12.

BH-1.11 FOSTER FAMILY HOME - AGED PERSONS

BH-1.11

A family home for aged persons is a family residence, noninstitutional in character, which receives for care, with or without compensation, no more than four persons who have reached the age of 65 years.

BH-1.12 SMALL GROUP CARE HOME - AGED PERSONS

BH-1.12

A group care home for aged persons is a residence, noninstitutional in character, which accepts for care, with or without compensation, 5-15 persons who have reached the age of 65 years. (See Handbook Sec. BH-1.21 for definition of institutional characteristics.)

BH-1.30 RECEPTION AND CARE OF AGED PERSONS

BH-1.30

Persons, corporations, or associations are subject to license as a home for the aged if they solicit and/or receive aged persons into a physical setting with the intention or practice of assuming for them responsibilities which go beyond that customarily associated with a landlord-tenant relationship. In determining the need for a license, the intention, obligations, or practices which shall be construed as indications or evidence of a need for a license, include the following:

1. Identification of the establishment and the service offered by any name, description or advertisement which implies a service to aged people other than that of housing, a place serving food to the public, a nursing or convalescent home, or a psychiatric care facility.
2. Implied or actual assumption of responsibility for general oversight and, as needed, personal care to aged persons, such as help with bathing, dressing, eating, care of clothing, mending, laundry, personal shopping, transportation, health supervision, assistance in maintaining social and recreational contacts, etc.

Any practice, intention or obligation which does not include all the services required in regulations governing the licensing of reception and care of the aged shall not, however, be presumed to excuse any person, corporation, or association from the need for a license.

These Regulations are designated to become effective July 1, 1961.

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
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BH-2.10 BOARDING HOMES FOR CHILDREN

BH-2.10

Boarding homes for children (BHC) are of two types as defined by Secs. BH-2.11 and BH-2.12.

BH-2.11 FOSTER FAMILY HOME FOR CHILDREN

BH-2.11

A family home, noninstitutional in character, which provides 24-hour care, with or without compensation, for not more than six children under 16 years of age, including children of the foster family under 16 years.

BH-2.12 SPECIAL BOARDING HOME FOR CHILDREN

BH-2.12

A family home, noninstitutional in character, which provides 24-hour care, with or without compensation, for 7 to 15 children under 16 years of age, including children of the foster family under 16 years. (See Sec. BH-2.52 for definition of institutional characteristics.)

BH-2.20 DAY-CARE HOMES - CHILDREN

BH-2.20

Day care homes are of two types as defined by Secs. BH-2.21 and BH-2.23.

BH-2.21 FAMILY DAY-CARE HOMES - CHILDREN

BH-2.21

Family home noninstitutional in character, which provides day care only, with or without compensation, for not more than six children under 16 years of age, including foster family's children under age 16.

BH-012.10 FACILITIES FOR AGED

BH-012.10

1. Foster family homes for aged persons as defined by Sec. BH-1.11.
2. Small group care homes for aged persons as defined by Sec. BH-1.12.

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BH-012.20 FACILITIES FOR CHILDREN

BH-012.20

1. Foster family homes for 24-hour care of children as defined by Sec. BH-2.11.
2. Special boarding homes for 24-hour care of children as defined by Sec. BH-2.12.
3. Family day care homes for children as defined by Sec. BH-2.21.
4. Special day care homes for children as defined by Sec. BH-2.23.
5. Parent-child boarding homes for parent and children as defined by Sec. BH-2.31.

BH-021.20 RETENTION AND DESTRUCTION OF CASE RECORDS

BH-021.20

Records shall be maintained intact for five years after the application is denied or withdrawn, or the license becomes ineffective. Thereafter, all material may be destroyed except:

1. Information necessary for auditing purposes (i.e., index cards for licensed cases).
2. The records of licensees who have filed an appeal from revocation of license or denial of a renewal application. These records shall be retained permanently.

If no application was filed (i.e., cc's), correspondence and/or recording may be destroyed two years after the last contact.

BH-024.11 CENTRAL VACANCY FILE

BH-024.11

Each accredited agency shall establish a procedure through which it is possible to identify all licensed homes currently available for use (i.e., all BHA's which have vacancies and all BHC's not allocated for the exclusive use of a child-placing agency. See BH-014.30.)

If a separate "vacancy file" is not maintained, identifying tabs and needed information shall be placed on the cards in the Master File or Central Registry. (See BH-024.10 - 024.13 - Handbook.)

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BH-014.20

DELEGATION TO LOCAL AGENCIES

Regulations

BH-014.20 QUALIFICATIONS OF STAFF - LICENSING WORKERS

BH-014.20

Workers who receive licensing assignments after June 30, 1961, shall have either status in the class or the qualifications for their position title (or for a comparable title) as established in the class specifications for that title, adopted by the Social Welfare Board for the Merit System.

BH-014.25 QUALIFICATIONS OF STAFF - SUPERVISORS

BH-014.25

Supervisors assigned to any phase of the licensing program after June 30, 1961, shall have either status in the class or the qualifications for their position title as established in the class specifications for that title, adopted by the Social Welfare Board for the Merit System.

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Rev. 147 replaces Issue 01-12

Effective 7/1/61

CONTINUATION SHEET
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(Pursuant to Government Code Section 11380.1)

BH-024.12 CENTRAL REGISTRY

BH-024.12

Each accredited licensing or inspection agency shall maintain a central registry of all licensed homes within the agency's jurisdiction, in order that there may be one central source of information to the public.

The Master File may be used or adapted for this purpose.

This information must be made accessible to the public.

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BH-024.20 CASE PROCESSING CONTROLS

BH-024.20

Accredited agencies shall maintain card files and controls on:

1. Pending applications
2. Annual renewals
3. Inquiries, homes reported to be operating without license, complaints, etc.
4. Any required clearances (e.g., fire, sanitation, tuberculin skin test or X-ray, etc.).

BH-104 APPLICATION FOR LICENSE

BH-104

Any person shall have the right to file an application for license.

A person who wishes to file an application shall be given an opportunity to do so even when it is known that licensing standards are not met, or that aged guests or children are not available for placement.

Persons currently caring for children or aged persons and intending to continue such care shall be instructed to file an application.

A new application shall be filed whenever there is any change in type of care, change in location or change in the persons responsible for providing care. See Secs. BH-107.31 and BH-107.43 - BH-107.45.

A new application is also required when a renewal application was not filed within the legal time limit. See BH-108.28.

The appropriate application form (BHA 10 - Application for License to Operate a Private Home for Aged or BHC 10.1 - Foster Home Application) shall be completed and signed by the applicant.

BH-105 STUDY OF APPLICATION

BH-105

The licensing agency shall complete a study of each application received.

Each study shall include all steps necessary to determine whether applicable licensing standards are or are not met. (See Secs. BH-105.10 through BH-105.60.)

The study shall be completed within 90 days after the receipt of application, unless there are factors beyond the control of the agency (e.g., failure to receive necessary reports or clearances, etc.).

These Regulations are designated to become effective July 1, 1961.

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BH-104.10

LICENSING PROCESS

Regulations

BH-104.10 PRE-APPLICATION SERVICE

BH-104.10

Potential applicants (husband and wife or both partners in a proposed BHA, if pertinent) shall be asked to come to the office for an intake interview, unless this is not a reasonable requirement (e.g., because of the distance involved, etc.).

If group meetings for potential applicants are held, the office interview may precede or follow the group session, but a group meeting shall not be used as a substitute for the required office intake interview.

Intake interviews shall be planned to:

1. Secure information about the motivations and qualifications of potential applicants.
2. Interpret in general terms, the licensing laws, the standards applicable to the type of care planned, the way in which the agency determines eligibility to license, and what would be involved for an applicant in securing a license (i.e., agency contacts with references and any necessary clearances and verifications).
3. Help potential applicants decide whether the responsibilities involved in foster parenthood or care of aged persons are consistent with their needs, interests and capacities.
4. Provide a basis for mutual decision as to whether there is reasonable expectation that the requirements for license can be met.
5. Help potential applicants decide whether they wish to file an application, consider further the information received, or abandon their plans to care for children or aged persons.
6. Develop plans for any next steps indicated by the decisions reached (e.g., another office interview after information about zoning requirements has been secured, home visit after an application is filed, etc.).

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BH-105.51 FIRE SAFETY

BH-105.51

Requests for inspection shall be sent to an appropriate fire official for the following: (Form BH-23.7 is available for this purpose.)

Aged Homes

1. Homes requesting a license to care for more than six aged persons.
2. Homes planning to care for any nonambulatory persons. For this purpose, a "nonambulatory" person means any guest who is incapable of leaving the building without assistance of any type in the event of an emergency.
3. Homes which appear to present a fire hazard.

Children's Boarding Homes

1. Homes planning to care for more than six children, including own children.
2. Homes located in a federal housing project.
3. Homes which appear to present a fire hazard.
4. Homes in which there is a plan to use a temporary structure for the care of foster children in an expanded summer program.

Making Requests for Fire Inspection

If local fire inspection is not available, requests for inspection shall be sent to the appropriate district office of the State Fire Marshal in San Francisco, Sacramento or Los Angeles.

Requests shall include the following:

1. Name and address of home.
2. Clear directions for reaching home
3. Description of building.
4. Any observed fire hazard.
5. Number and ages of foster children.
6. Number of aged persons and any pertinent information on their physical condition.
7. When appropriate, the changes necessary to make any portion of the building safe for the care of nonambulatory aged persons.

Withholding of License

When a fire inspection is required, a license shall not be issued until a fire clearance is received.

These Regulations are designated to become effective July 1, 1961

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Regulations

LICENSING PROCESS

BH-105.83

BH-105.83 TERMS OF THE LICENSE

BH-105.83

1. General

The license shall specify the maximum number of foster children or aged guests to receive care at any one time.

When continued care of a particular child or aged person requires special permission, the license shall specify the name of each person whose care is so authorized.

Any other limitations indicated by the study shall be written on the license or included in the transmittal letter.

2. Boarding Homes for Aged Persons

Unless the care of nonambulatory aged persons has been approved by fire safety officials, each BHA license shall state "Ambulatory aged only." When such approval has been given, the license must specify the number of nonambulatory persons included in the licensed capacity and any limitations on the rooms which they may occupy. (See Sec. BH-105.51.)

3. Boarding Homes for Children (day care and 24-hour care)

The license issued to a foster home for children shall specify (1) the age range and sex of the foster children and (2) the type of care authorized (i.e., "For day care only;" "For 24-hour care only" or "For parent-child care only").

Unless requirements for a "Special license" are met, the number of foster children specified on the license and the number of children in the foster family less than 16 years of age shall not total more than six.

A license with a minimum age range of less than two years shall also specify the number of foster children under two years of age who can be accepted for care. Unless the requirements of Item 1 in Sec. BH-124.21 can be met, this number shall not exceed the following:

1. None, if the foster family has two or more children under two years of age.
2. One, if the foster family has one child under two.
3. Two, if there will be other children over two years of age in the home (i.e., own children or foster children).

Care of more than two children under two years of age shall be authorized only when there will be no other children in the home and an exception is warranted by some unusual factor (e.g., care required by three brothers and sisters under two years of age; care will be given by two adults, etc.).

(Continued)

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BH-105.83 (Continued)

BH-105.83

When foster parents and/or other members of the household have claimed exemption from the requirements relating to intradermal tuberculin tests and chest X-rays on the basis of their religious faith, the license shall be limited to the care of children of the same faith. (See W&IC Sec. 1632).

For foster homes which operate a summer program for a larger number of children, the license shall clearly state both the number of children permitted for year-round care and the number of children permitted for summer care. If the summer capacity has not been determined at the time license is issued for year-round care, a new license shall be issued when the summer capacity is determined. This license shall indicate the number permitted for year-round care, as well as the number for whom summer care is authorized.

BH-105.91 LICENSING AGENCY

BH-105.91

When it is necessary to recommend denial of a new application, this action shall be carefully discussed with the applicant and if any children or aged guests are living in the home, a plan and date for the discontinuance of care shall be agreed upon.

Unless the applicant elects to withdraw his application, a letter of denial shall be sent to the applicant confirming the prior discussion. This letter shall (1) state that the application is denied (2) review the reasons for this decision and (3) confirm any plan for the discontinuance of unlicensed care. The reasons given shall represent a true statement of fact but need not include a detailed listing of all factors which contributed to the denial decision. (See Handbook section.)

Whenever it is known that children or aged persons living in the home have been placed by or through public or private welfare agencies (e.g., county welfare department; probation department; California Youth Authority, Catholic Welfare Bureau, etc.), notification of the plan to deny a license shall be given to the agency concerned.

BH-107 SUPERVISION OF LICENSED HOMES - AGED AND CHILDREN

BH-107

Interim visits shall be made to (1) insure that the welfare of children or aged persons is properly protected and (2) help licensees improve the quality of care provided.

Priority shall be given to work with new licensees and with those who were not in full conformity with regulations when the last license was issued.

When it is evident that requirements are not met, applicable standards shall be explained and a plan developed to correct deviations or achieve conformity with the terms of the license within an appropriate time limit. (See Handbook.)

At least two supervisory visits shall be made before the expiration of the current license. One of the required visits may be the visit made as part of the renewal study. See Sec. BH-108.21. (W&IC 2301 requires a minimum of two visits each year.)

These Regulations are designated to become effective July 1, 1961.

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LICENSING PROCESS

BH-107.33

BH-107.33 CHANGE IN TERMS OF AN UNEXPIRED LICENSE

BH-107.33

1. An amended license shall be issued when there is need to change the terms of an unexpired license.

An amended license may:

- a. Authorize a requested increase in capacity.
- b. Authorize the care of a named person whose admission or continued care requires special permission (e.g., a mentally retarded child; a nonambulant aged person, etc.).
- c. Remove or decrease limitations in care when these restrictions are no longer necessary (e.g., limitations in age range, care of named persons only, etc.).
- d. Add limitations or reduce capacity on (1) receipt of a request or (2) completion of applicable procedures listed below.

An amended license with less restrictive terms shall only be issued when the home can meet the necessary requirements.

2. When investigation indicates that the licensed capacity should be reduced or new limitations placed upon an unexpired license, the reasons for this decision shall be explained. If the licensee agrees to the proposed change, he shall be requested to return his current license and advised that an amended license will be issued on receipt of the prior license.

If the licensee is dissatisfied with the decision to modify the terms of his license, his right of appeal and the 30-day limit for filing an appeal shall be explained.

If his attitude remains unchanged at the end of the interview, a registered letter shall be sent to the licensee (a) enclosing the amended license and (b) confirming the verbal explanation of the reasons for the decision to modify the license, the right of appeal and the 30-day limit for filing an appeal.

On receipt of an appeal, the accredited agency shall immediately notify the Area Office of the SDSW in the manner required when an appeal from the denial or modification of a renewal license is received. (See Sec. BH-108.26.)

If an appeal is not received within 30 days, a letter shall be sent to the licensee (a) explaining that the time limit for filing an appeal has expired and (b) requesting that the ineffective license be returned.

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LICENSING PROCESS

BH-108.21

BH-108.21 CONTENT OF RENEWAL STUDY

BH-108.21

The renewal study shall include:

1. At least one visit to the applicants' home,
2. A review of the register (Form BHA 50, BHC 50 or BHC 50.1) giving information about the children or aged persons under care during the past year to determine compliance with the requirements concerning (a) the maintenance of a register and (b) adherence to the limitations of the last license. (See Sec. BH-115, BH-124, BH-124.44)
3. A review of the tuberculin test and/or chest X-ray reports on file in the home to determine whether all necessary reports have been obtained during the last twelve months. (See Handbook Sec. BH-120.24)
4. Any clearances required to determine continued conformity with state laws and regulations relating to housing, fire safety and sanitation. (See Sec. BH-108.22.)
5. Any necessary verification that other standards are currently met.
6. Any information available from staff in other units or agencies or from individuals about the quality of care provided during the previous year. Such information shall be obtained when:
 - a. A 24-hour BHC is allocated to an agency for its exclusive use.
 - b. A BHA serves public assistance recipients.
 - c. It is practical to contact parents of children receiving day care or care in an independent boarding home, and relatives of aged persons living in BHAs not serving recipients of public assistance.
7. Evaluation of all findings in terms of service to children or aged persons.

 This evaluation shall be based on information received by the licensing worker during the past year, as well as on the findings of the renewal study.
8. Recording of the evaluation, as well as the information on which it is based.

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LICENSING PROCESS

BH-108.26

BH-108.26 MODIFICATION OR DENIAL OF RENEWAL LICENSE

BH-108.26

1. Modification of License

When a renewal application requests a license with terms identical with those of the last license issued and decision is made to issue a more restrictive license (e.g., reduced capacity, care of named persons only, further limitations in the age range of children, etc.), the reasons for this decision shall be carefully discussed with the licensee. If the licensee indicates that he is dissatisfied with this decision, the right of appeal shall be explained.

When the license is issued, it shall be sent to the licensee with a registered letter explaining the reasons for modification in the terms of the license, the right of appeal from a change in the terms of the license, and the time limit for filing an appeal (30 days).

If the decision involves a boarding home for aged persons, this letter must be sent at least 30 days prior to the expiration of the current license. (See W&IC Sec. 2303)

2. Basis for Denial

A renewal license shall be denied when any of the following conditions are found during a renewal study:

- a. Evidence of mistreatment or neglect of children or aged persons (either physical or emotional) which the licensee is unable or unwilling to correct.
- b. Refusal or failure to correct a life or health hazard within a reasonable period of time after the need for correction has been explained.
- c. Refusal or failure to correct other deviations from regulations which jeopardize the welfare of children or aged persons, within the time limit established.
- d. Persistent violation of the terms of the license.

When it is necessary to recommend denial of a renewal application, an interview shall be arranged to explain (a) the reasons for denial, (b) the fact that withdrawal of the application is possible, (c) the right of appeal and (d) the 30-day time limit for filing an appeal. If interest in filing an appeal is expressed, the appeal procedure shall be appropriately explained. (See Handbook.) If the licensee has no interest in filing an appeal, a plan and date for termination of care shall be agreed upon.

(Continued)

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BH-108.26

LICENSING PROCESS

Regulations

BH-108.26 (Continued)

BH-108.26

Unless the licensee elects to withdraw his renewal application, this discussion shall be confirmed in a registered letter which (a) states that the application is denied, (b) lists the reasons for denial in terms of the acts or conditions which constitute violation of the standards, (c) reviews the right of appeal and the legal time limit for filing an appeal, and (d) if pertinent, reminds the licensee of the established date for termination of care.

Any letter notifying the operator of a boarding home for aged persons that his renewal application will be denied must be mailed at least 30 days prior to the expiration of his current license. (See W&IC Sec. 2303)

3. Right of Appeal

On receipt of an appeal from a denial or modification of a renewal license, the accredited agency shall immediately notify the area office of the SDSW in writing, giving the name and address of the licensee and all pertinent information including licensing history, the basis for denial or modification of the license and a summary of the agency's efforts to correct the situation.

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Rev. 109 replaces Rev. 39

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BH-108.20 STUDY OF RENEWAL APPLICATION

BH-108.20

On receipt of a renewal application, a renewal study shall be completed before the current license expires unless there are factors beyond the control of the agency (i.e., failure to receive necessary reports or clearances, etc.).

When there is substantial doubt that a boarding home for aged persons is eligible for license, the renewal study shall be completed at least 30 days prior to the expiration of license. (See Sec. BH-108.26.)

BH-111.10 PERSONAL QUALIFICATIONS OF OWNER-MANAGER

BH-111.10

1. All licensees shall be of such age and state of health as to be capable of undertaking the care of aged persons.
2. Persons caring for the aged shall be of good character and be temperamentally capable of liking older people and of understanding their motivations, fears, and desires.
3. All licensees shall have a background of education, training or experience which assures their ability to provide care for aged persons, and when feasible, shall be willing to enroll in any available courses designed to increase this ability.
4. Satisfactory references shall be furnished by each new applicant for a license.

BH-113.40 HEALTH EXAMINATIONS FOR NEW RESIDENTS

BH-113.40

Each boarding home shall require prior to admission or final acceptance, a health examination for each aged person.

This health examination shall include:

1. A written report of a recent examination from the examining physician. (Form BHA 52 is available for this purpose.)

If the aged person has been under a physician's care, this report shall be obtained from the person's own physician.

If the aged person has been referred by a hospital or nursing home, a report shall be obtained from the attending physician or social service department.

If the person has not been under a physician's care, he shall be requested to obtain from a physician of his choice an examination and evaluation of his health status.

2. A chest X-ray if there is a history of tuberculosis.

Exception:

The physician's examination and chest X-ray may be waived for persons belonging to a faith relying on prayer or other spiritual means of healing, provided all other indications are that the person meets the admission requirements in Regulation BH-113.20.

These Regulations are designated to become effective July 1, 1961.

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BH-114.33

STANDARDS FOR BOARDING HOMES FOR AGED

Regulations

BH-114.33 FIRE SAFETY

BH-114.33

Homes which require an annual fire clearance include the following:

1. Any home caring for more than six aged persons.
2. Any home caring for a nonambulatory person. With respect to fire safety, a nonambulatory person is any person unable to leave the building without assistance of any kind in the event of an emergency.

Nonambulatory persons shall be cared for only if special provisions for their safety have been made which meet the requirements of the State Fire Marshal.

3. Any other home which appears to represent a fire hazard.

No aged guest shall be housed above the second floor of any building without approval of the fire safety inspector.

BH-114.34 FIRE SAFETY STANDARDS

BH-114.34

All homes for the aged required to have a fire clearance (BH-114.33) shall comply with the fire safety laws of the state and the rules and regulations of the State Fire Marshal governing homes for the aged contained in Title 19 of the California Administrative Code.

A fire clearance from the appropriate fire official is required before initial license, before renewal of license, and before any change in the terms of the license which affects fire safety.

Denial of a fire safety clearance is cause for denial of an application or for revocation of a license.

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Rev. 133 replaces Rev. 6

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Regulations STANDARDS FOR BOARDING HOMES FOR AGED BH-114.53

BH-114.53 SLEEPING ACCOMODATIONS

BH-114.53

Homes shall provide bedrooms suitably furnished and sufficient in number and size to accommodate the residents of the home. Bedrooms in buildings newly licensed after the effective date of this regulation shall not be used for occupancy by more than two aged persons.

A. Location of Bedrooms

No unfinished attic, stairway, hall or room commonly used for other purposes shall be used as a sleeping room for any aged resident.

No bedroom shall be used as a passageway to another room, bath or toilet.

Bedrooms located above the first floor shall be restricted to occupancy by persons who can climb stairs easily.

Bedrooms in detached buildings shall be restricted to occupancy by persons who are mentally and physically active.

B. Furnishings

Individual beds shall be provided for each resident except married couples.

Each bed shall be furnished with good springs, a clean comfortable mattress and adequate, light, warm bedding.

Closets and drawer space shall be provided for the clothing and for the personal belongings of the residents.

C. Size of Bedrooms

Bedrooms shall be large enough for the placement of needed furniture and to allow for easy passage between beds and other items of furniture.

Private bedrooms shall have a minimum of 100 square feet of superficial floor area per person. Bedrooms for two or more persons shall have a minimum of 70 square feet of superficial floor area per person.

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MC-020 WHO ARE ELIGIBLE TO RECEIVE SERVICES

MC-020

Medical and related services and supplies are available under Chapter 1, Part 3, Division 5 of the W&IC to the following:

Recipients of Old Age Security
Recipients of Aid to Needy Blind
Recipients of Aid to Potentially Self-supporting Blind Residents
Children included in the family budget unit under the Aid to Needy
Children Program
Children in Boarding Homes or Institutions receiving Aid to Needy
Children
Needy parents (including incapacitated parents) or needy persons
taking the place of parents, living with children receiving
Aid to Needy Children
Recipients of Aid to Needy Disabled

A person who is not receiving aid solely for the reason that aid is withheld to adjust for a previous overpayment is nevertheless entitled to medical care.

A person whose aid is suspended solely for determining the amount of aid he should receive is nevertheless entitled to medical care.

Payment under the Medical Care Trust Fund Program is not available for recipients whose income is sufficient to meet their nonmedical needs and/or nursing home needs, and who consequently have assistance funds up to the statutory maxima available to meet their medical needs.

MC-018 CERTIFIED REHABILITATION FACILITY

MC-018

A public or private rehabilitation facility certified by the California State Department of Public Health as meeting the standards adopted by the State Department of Social Welfare. (MC-031.6,D)

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MC-020.1 ELIGIBILITY OF ATD RECIPIENTS TO RECEIVE SERVICES

MC-020.1

ATD recipients eligible for functional improvement services,
within the limitations of the Medical Care Fund are those:

1. Who can benefit from physical restoration or achieve a greater degree of self-care through the receipt of specified services and assistive devices, and
2. Who show evidence of sufficient feasibility and motivation to warrant expenditures, and
3. For whom the required services are not otherwise available or accessible.

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SCOPE AND LIMITATIONS

MC-031.4

MC-031.4 ATD FUNCTIONAL IMPROVEMENT PROGRAM

MC-031.4

The ATD Functional Improvement Program is a planned use of medical care, social services and assistive devices directed toward improved self-care and prevention of disability. It provides care in the home from local resources to recipients for whom rehabilitation center treatment is not appropriate or available.

The purpose is accomplished by integrating medical and social services available to all with additional functional improvement services, according to an individualized plan designed to restore function, prevent deterioration or increase independence.

A functional improvement plan requires a current and complete medical assessment by a qualified physician. It also requires an evaluation of the medical findings in light of the recipient's motivation and social circumstances, and any available information concerning other physicians' and agencies' experiences with him. Functional improvement likewise requires coordinated medical, social and ancillary services, sometimes complemented by the use of assistive devices or housing modifications.

Services available to all (medical, nursing, laboratory, physical therapy, etc.) are subject to the prior authorization procedures including waiver of prior authorization, as outlined in Sections MC-031.1, MC-031.6, and MC-053.50. Additional functional improvement services always require prior authorization.

The additional services are:

1. Occupational therapy of a functional nature, including evaluation and alleviation of self-care limitations through instruction, retraining, and the use of devices.
2. Appliances and assistive devices (excluding dentures, hearing aids and glasses), if not available from other sources in the community.
3. Household rehabilitation equipment, including bathroom rails, parallel bars, modified chairs and toilet seats, pulleys, overbed trapeze bars, bedboards, devices to aid dressing and eating, etc. (See ATD Manual Sec. D-202.20 for items allowable within the grant.)

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Rev. 340 replaces Rev. 263

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MC-031.5

SCOPE AND LIMITATIONS

Regulations

MC-031.5 EXPENDITURE LIMITATIONS ON ATD FUNCTIONAL IMPROVEMENT PROGRAM

MC-031.5

Special functional improvement services requiring prior authorization shall not exceed \$400 in any 12 months period. Expenditures above the maximum may be authorized by the SDSW if exceptional need is shown to exist.

Provisions regarding expenditures apply until September 30, 1961, by which time they will be reevaluated by SDSW.

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Regulations

SCOPE AND LIMITATIONS

MC-031.6

MC-031.6 SERVICES AVAILABLE WITH
PRIOR AUTHORIZATION

MC-031.6

I. Services for which prior authorization may be waived (MC-053.50)

- A. Home and/or office visits from or to practitioners (other than dentists and chiropodists) in excess of three such visits for any other illness or beyond the 90th day from the first visit.
- B. Any service rendered by podiatrists.
- C. For Aid to Needy Children recipients only special medical supplies not listed in the schedule of maximum allowances, but required as a part of a specific treatment plan.
- D. Elective laboratory services other than urinalysis and blood counts.
- E. Elective radiological and outpatient radiotherapy services.
- F. Services of private nurses, visiting nurse associations, or nurses in public agencies rendering home nursing in excess of five visits for any one illness.
- G. Dental care for children under 13 years of age as necessary to prevent tooth loss and maintain dental health. During the fiscal year beginning July 1, 1960, and ending June 30, 1961, such care may also be given to children aged 13 through 17 years.
- H. Complete histories and physical examinations by physicians.
- I. Services of physical therapists as prescribed by physicians.
- J. For OAS recipients all essential dental care necessary to restore and maintain adequate dental health pursuant to standards established by the Director of the SDSW.
- K. Elective office surgery.

II. Services for which prior authorization may not be waived.

- A. Services of rehabilitation facilities meeting the standards of the Vocational Rehabilitation Service.
- B. For Old Age Security recipients only, eye appliances listed in the Schedule of Maximum Allowances. (MC-045.1)
- C. For OAS recipients only, medical and osteopathic services and laboratory tests necessary for a comprehensive annual health evaluation. (Effective 7/1/61)
- D. For OAS and ATD recipients only, care, services, supplies, and equipment determined by a certified rehabilitation facility as necessary during the period the rehabilitation plan is in effect. (See MC-018)

CALIFORNIA-SDSW-MANUAL- MC

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Regulations

SCHEDULE OF MAXIMUM ALLOWANCES

MC-040

MC-040

SCHEDULE OF MAXIMUM ALLOWANCES

MC-040

The following allowances constitute the maximum payment that may be made for the specified service or procedure. No additional charge to the recipient will be permitted.

No payment, except as noted below, will be made for any service, care or procedure furnished by a hospital or facility, including an adjunct nursing home operated as part of such hospital.

Exceptions:

1. Outpatient services, such as diagnostic laboratory, X-ray, physical therapy, or procedures performed on an emergency outpatient basis.
2. For Old Age Security recipients only, dental care, refractions and eye appliances.
3. For Old Age Security and Aid to the Disabled recipients, rehabilitative services furnished by a certified rehabilitation facility.

No payment will be made for diagnosis or treatment given in the absence of the recipient, e.g., telephone calls.

Payment may be made for physician's services only when performed with a physician in attendance.

No payment will be made for the treatment of mental illness.

Under the Aid to Needy Children program payment will be made for the treatment of tuberculosis, venereal disease, and for prenatal care. Payment for these conditions will not be made for recipients under other public assistance programs.

No payment will be made for rehabilitative services at a rehabilitation facility unless the practitioner submits a complete plan for rehabilitation in advance of referral.

This schedule includes most procedures contemplated as necessary and normally performed in any locality on an outpatient basis. However, other procedures may be included if they are determined to be in accordance with local community practice.

CALIFORNIA-SDSW-MANUAL- MC

Rev. 366 replaces Rev. 286

Effective 6/1/61

DO NOT WRITE IN THIS SPACE

CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

MC-040.2 SCHEDULE OF MAXIMUM ALLOWANCES Regulations

MC-040.2 SURGERY MC-040.2

Listed procedures indicated by an asterisk: Fee for Surgery only. Follow-up care--charge per visit
See Schedule for Visits and Examinations.

All other services include two weeks' postoperative care.

In multiple surgical procedures, in remote operative fields and separate incisions, an additional
50 percent of the minor fee will be paid.

Two physicians may not be paid for attendance on the same case at the same time except where it is
warranted by the necessity of supplementary skills.

Cast materials, dressings and retention catheters may be charged for separately at cost.

Values for X-ray and laboratory procedures are listed elsewhere in this schedule.

No payment will be made for cosmetic surgery.

INTEGUMENTARY SYSTEM

Skin and subcutaneous Areolar Tissue

Incision

*0101	Drainage of infected steatoma.	.\$4.00
*0102	Drainage of furuncle	4.00
*0108	Drainage of carbuncle.	4.00
*0114	Drainage of subcutaneous abscess (where not specified elsewhere)	4.00
*0115	Drainage of pilonidal cyst	4.00

(Continued)

CALIFORNIA-SDSW-MANUAL-MC Rev. 367 replaces Rev. 229 Effective 6/1/61

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CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATIONS
 WITH THE SECRETARY OF STATE**
 (Pursuant to Government Code Section 11380.1)

Regulations

SCHEDULE OF MAXIMUM ALLOWANCES

MC-041

MC-041

SERVICES BY PUBLIC OR VOLUNTARY CLINICS AND TEACHING
 FACILITIES

MC-041

Maximum payments allowable for services rendered in public, voluntary and teaching facilities are limited as follows:

1. Public hospitals: 75 percent of the allowances shown in the schedules of maximum allowances.
 (See "a" and "b" below.)
2. Teaching facilities not constituting a public hospital and nonprofit associations using donated services from community practitioners:

75 percent of the allowances shown in the schedules of maximum allowances except MC-040.3 (radiology), MC-040.4 (pathology) and MC-048 (physical therapy) for which services the maximum is 100 percent of the schedule.
 (See "b" below.)

3. Teaching facilities and nonprofit associations not using donated services from community practitioners:

100 percent of the allowances shown in the schedules of maximum allowances, provided the management of the facility or association has filed a certificate with the SDSW stating it does not use donated services. (See "b" below.)

Exceptions:

- a. Public facilities which provide home nursing services, actual cost, as determined by current cost analysis, not to exceed \$4.50 per visit. (MC-047)
- b. Certified rehabilitation facilities in accordance with the schedule of maximum allowances in MC-045.5.

DO NOT WRITE IN THIS SPACE

CALIFORNIA-SDSW-MANUAL-MC

Rev. 368 replaces Rev. 314

Effective 6/1/61

CONTINUATION SHEET
R FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

MC-043	SCHEDULE OF MAXIMUM ALLOWANCES	Regulations
MC-043	PODIATRY	MC-043
10	Routine office visit	\$ 4.00
20	Routine home visit	6.00
30	Home visit - each additional member, same household, maximum total any one visit \$12.00	3.00
35	Mileage per mile, one way, beyond radius of 10 miles office or home	.80
40	Roentgenograms:	
41	Toes	6.00
42	Foot	8.00
43	Ankle	8.00
44	Additional views	4.00
50	Fractures - closed reductions (includes application of first cast and two weeks postoperative care)	
51	Tarsal	32.00
52	Metatarsal	28.00
53	Phalanx	12.00
60	Plaster casting procedure for conditions other than fractures Foot and/or ankle	8.00
70	Flexible casting	
71	Unna boot, Pressoplast, Contoura lower leg bandaging - per leg	8.00
72	Adhesive strappings	4.00
80	Surgery	
81	Drainage or puncture aspiration of abscess, hematoma, onychia, paronychia (with or without partial avulsion of nail)	4.00
82	Incision and removal of foreign body, subcutaneous tissues, simple	8.00
83	Incision and removal of foreign body, subcutaneous tissues, complicated	By report
84	Excision of nail, nail bed or nail fold, partial	8.00
85	Excision and/or direct repair, lineal scar or wound up to 1/8 inch wide and 1/2 inch long	12.00
86	each additional 1/2 inch	4.00

(Continued)

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Regulations

SCHEDULE OF MAXIMUM ALLOWANCES

MC-043

MC-043 (Continued)

MC-043

87	Local destruction of small benign, neoplastic, cicatricial, inflammatory or congenital lesions, one	\$12.00
88	more than one	16.00
89	Chemocautery of verrucae or neuro-fibrous lesions, per visit	4.00
90	Tenotomy	12.00
91	Burns, initial treatment, first degree, where no more than local treatment necessary	6.00
92	dressing, initial, without anesthesia	8.00
93	Bursa, drainage of infected bursa	8.00
94	Puncture for aspiration, initial	8.00
95	subsequent	6.00
96	Anesthesia, local	4.00

The above services under 50, 60, 70 and 80 do not justify a separate charge for the office or home visit during which the service is given.

DO NOT WRITE IN THIS SPACE

CALIFORNIA-SDSW-MANUAL- MC

Issue No. 04-30

Effective October 1, 1957

CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Regulations

SCHEDULE OF MAXIMUM ALLOWANCES

MC-045.5

MC-045.5 SERVICES BY CERTIFIED REHABILITATION FACILITY - OLD AGE SECURITY MC-045.5
AND AID TO DISABLED ONLY

A. Hospitalization

Basic services, exclusive of
board and roomPer diem rate
approved by
SDSW.

B. Special services and equipment if not included in per diem rate:

1. Eye Care, Dental Care
and SurgeryAt actual cost
not to exceed
schedule of
maximum allowances.

2. Prostheses

Prostheses Fee
Schedule estab-
lished by the State
Department of
Public Health.3. Braces, Assistive devices,
Equipment

Community rate.

4. Repairs for #2 and #3

Community rate.

5. Home Care

Per diem rate
or schedule of
maximum allowances
for component
services.

6. Ambulance

Community rate.

DO NOT WRITE IN THIS SPACE

CALIFORNIA-SDSW-MANUAL- MC

Issue 04-52

Effective 6/1/61

CONTINUATION SHEET
 R FILING ADMINISTRATIVE REGULATIONS
 WITH THE SECRETARY OF STATE
 (Pursuant to Government Code Section 11380.1)

MC-053.70 AUTHORIZATION OF SERVICES UNDER FUNCTIONAL IMPROVEMENT PROGRAM MC-053.70

County authorization of services provided by Sec. MC-031.4 shall be based upon a decision by the county team (MC-054) that the case is potentially feasible for functional improvement services. SDSW authorization is necessary only as required by Sec. MC-031.5.

MC-022 FACILITIES

MC-022

Payment from the Medical Care Trust Fund Program may be made, within the maxima allowed, for services rendered by private practitioners, group practices, public clinics or voluntary clinics and hospitals, but, insofar as practical, no recipient shall be deprived of free choice of practitioner willing to provide services under the terms of these rules and regulations.

MC-030 SCOPE AND LIMITATIONS

MC-030

DO NOT WRITE IN THIS SPACE

These Regulations are designated to become effective June 1, 1961.

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

MC-054

PROCEDURAL REQUIREMENTS

Regulations

MC-054 PROCEDURAL REQUIREMENTS - IDENTIFICATION OF FIP

MC-054

The identification of applicants or recipients who are potentially feasible for functional improvement services shall be made on all cases as follows:

- (a) By the county after a team decision of the county medical consultant, social worker, medical social worker (when available) and other specialists as needed.
- (b) By the SDSW in the course of determining disability.

Evaluation and Treatment Procedures (For scope see Section MC-031.4)

For cases identified as potentially feasible for functional improvement services, the county shall (a) Secure the necessary evaluation work-up and, when indicated, (b) Develop a suitable treatment plan. Such evaluation and treatment plan shall be completed within 60 days following identification of the recipient.

All cases shall be processed to a point of decision. The county shall prepare in behalf of each recipient identified as feasible for FI services a statement which includes:

- (a) Summary of evaluation findings
- (b) Description of Proposed plan for functional improvement services
- (c) Estimate of duration of plan
- (d) Estimate of cost
- (e) Date plan is to be re-evaluated.

Functional improvement plans shall be re-evaluated as often as necessary during the course of treatment and at termination of treatment. Plans no longer valid in relation to factors listed in MC-020.1 or for other appropriate reasons shall be discontinued.

The county shall maintain a system of records which enables the county and the SDSW to review and evaluate the results of the ATD Functional Improvement Program. The county shall use the evaluation methods prescribed in Handbook Secs. MC-054 through MC-054.43.

DO NOT WRITE IN THIS SPACE

CALIFORNIA-SDSW-MANUAL-MC

Rev. 379 replaces Rev. 241

Effective 6/1/61

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Regulations

AID PAYMENTS

D-221

D-221 AMOUNT OF AID PAYMENT

D-221

Aid is to be paid monthly, subject to the limitations of W&IC 4020, in the nearest whole dollar amount determined by subtracting the recipient's current net income received in the month (as determined in accord with Chapter D-21) from his allowable needs for the month (as specified in Chapter D-20).

The aid payment cannot exceed \$106 except when a special need is allowed. (See Secs. D-203, D-204.47)

Payment is to be authorized, changed, suspended, denied or discontinued by use of Form ABD 278 or an approved substitute. (See Sec. D-025, Form ABD 278.)

In determining the amount of the aid payment for a particular month, all income and those allowable needs which existed and were reported before the end of that month are considered. Exceptions: 1) when the change could not have been known or reported before the end of the month because it occurred too late to give the recipient reasonable time to report within the month or the report was not received due to communication difficulties, etc., such change is to be reflected in the aid payment if reported by the end of the following month. 2) When special circumstances, such as the recipient's physical or mental incapacity, make it unreasonable to expect that he could have reported promptly, such change is reflected in the aid payment for the months in which it existed, if reported as soon as could reasonably be expected.

DO NOT WRITE IN THIS SPACE

CALIFORNIA-SDSW-MANUAL-ATD

Rev. 459 replaces Rev. 390

Effective 6/1/61

CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

The following Department Bulletins are repealed effective June 1, 1961:

- 565 (Stat) Supplement to Social Data Record Card, Form BI 251-A
- 574 (Stat) Report on Concurrent Receipt of Public Assistance and
Old Age Survivors' Insurance in February 1959
- 583 (Stat) Survey of Distribution of Payments, October 1959
- 584 (Stat) Report on Concurrent Receipt of Public Assistance and Old
Age, Survivors' and Disability Insurance in Feb. 1960
- 598 (MC) Additional Medical Care for ATD Recipients, Effective
February 1, 1961
- 599 (MC) Elective Office Surgery and Outpatient Radiotherapy for
OAS, AB, ATD and ANC Recipients, Effective February 1, 1961
- 605 (BH) Central Registry of Boarding Homes

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CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATION...
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

071-05

WELFARE PERSONNEL STANDARDS

Organization and Administration

071-05 SALARY SCHEDULES (REVISED AS PROPOSED)
WPS

071-05

CLASSIFICATION

SCHEDULE OF STEPS

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)
GROUP A																	
County Welfare Director V	---	---	---	---	---	810	856	905	957	1012	1070	1132	1197	1266	1339	1416	1497
County Welfare Director IV	---	---	---	---	---	686	725	766	810	856	905	957	1012	1070	1132	1197	1266
County Welfare Director III	---	---	---	---	---	581	614	649	686	725	766	810	856	905	957	1012	1070
County Welfare Director II	---	---	---	---	---	491	519	549	581	614	649	686	725	766	810	856	905
County Welfare Director I	---	---	---	---	---	392	415	439	464	491	519	549	581	614	649	686	725
Asst. County Welfare Dir.	---	---	---	---	---	614	649	686	725	766	810	856	905	957	1012	1070	1132
GROUP B																	
Social Work Supervisor III	---	---	---	---	---	---	581	614	649	686	725	766	810	856	905	957	1012
Social Work Supervisor II	---	---	---	---	---	---	519	549	581	614	649	686	725	766	810	856	905
Social Work Supervisor I	---	---	---	---	---	---	464	491	519	549	581	614	649	686	725	766	810
Social Worker IV	---	---	---	---	---	---	464	491	519	549	581	614	649	686	725	766	810
Social Worker III	---	---	---	---	---	---	415	439	464	491	519	549	581	614	649	686	725
Social Worker II	---	---	---	---	---	---	371	392	415	439	464	491	519	549	581	614	649
Social Worker I	---	---	---	---	---	---	351	371	392	415	439	464	491	519	549	581	614
GROUP C																	
Child Welfare Supervisor II	---	---	---	---	---	---	581	614	649	686	725	766	810	856	905	957	1012
Child Welfare Supervisor I	---	---	---	---	---	---	519	549	581	614	649	686	725	766	810	856	905
Ch. Wel. Services Worker II	---	---	---	---	---	---	464	491	519	549	581	614	649	686	725	766	810
Ch. Wel. Services Worker I	---	---	---	---	---	---	415	439	464	491	519	549	581	614	649	686	725
Medical Social Work Supv.	---	---	---	---	---	---	519	549	581	614	649	686	725	766	810	856	905
Medical Social Worker	---	---	---	---	---	---	464	491	519	549	581	614	649	686	725	766	810
GROUP D																	
Admin. Service Officer II	---	---	---	---	---	---	581	614	649	686	725	766	810	856	905	957	1012
Admin. Service Officer I	---	---	---	---	---	---	491	519	549	581	614	649	686	725	766	810	856
Employment Officer	---	---	---	---	---	---	415	439	464	491	519	549	581	614	649	686	725
Financial Resources Supv.	---	---	---	---	415	439	464	491	519	549	581	614	649	686	725	766	810
Investigator	---	---	---	---	371	392	415	439	464	491	519	549	581	614	649	686	725
Medical Care Assistant	---	---	---	---	371	392	415	439	464	491	519	549	581	614	649	686	725
Systems & Proc. Analyst	---	---	---	---	519	549	581	614	649	686	725	766	810	856	905	957	1012
Chief Fiscal Officer	---	---	---	---	519	549	581	614	649	686	725	766	810	856	905	957	1012
Chief Fiscal Supervisor	---	---	---	439	464	491	519	549	581	614	649	686	725	766	810	856	905
GROUP E (SALARY DIFFERENTIALS FOR THE SPECIALTIES AT EACH LEVEL IN THIS GROUP MAY BE PERMITTED IF JUSTIFIED BY PREVAILING RATES)																	
SUPV CLERK II (GENERAL, BUDGET)	314	332	351	371	392	415	439	464	491	519	549	581	614	649	686	---	---
SUPV CLERK I (GENERAL, ACCOUNT, BUDGET)	281	297	314	332	351	371	392	415	439	464	491	519	549	581	614	---	---
CLERK III (GENERAL, TYPIST, STENO, ACCOUNT, BUDGET)	238	252	266	281	297	314	332	351	371	392	415	439	464	491	519	---	---
CLERK II (GENERAL, TYPIST, STENO ACCOUNT, BUDGET)	213	225	238	252	266	281	297	314	332	351	371	392	415	439	464	---	---
CLERK I (GENERAL, TYPIST, STENO)	190	201	213	225	238	252	266	281	297	314	332	351	371	392	415	---	---
ADDRESSING EQUIP OPR II	238	252	266	281	297	314	332	351	371	392	415	439	464	491	519	---	---
ADDRESSING EQUIP OPR I	213	225	238	252	266	281	297	314	332	351	371	392	415	439	464	---	---
Receptionist	213	225	238	252	266	281	297	314	332	351	371	392	415	439	464	---	---
Telephone Operator	201	213	225	238	252	266	281	297	314	332	351	371	392	415	439	---	---
Key Punch Operator	213	225	238	252	266	281	297	314	332	351	371	392	415	439	464	---	---
GROUP F																	
Medical Consultant	---	---	---	905	957	1012	1070	1132	1197	1266	1339	1416	1497	1583	1674	---	---
Homemaker	---	---	---	266	281	297	314	332	351	371	392	415	439	464	---	---	---
Student Social Worker Trainee (See Sec. 071-06 for determination of pay rates.)	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

For changes in pay ranges, see modification procedure specified in Sec. 071-10, Adoption of Compensation Plan, and Sec. 071-11, Adoption of Deviating Pay Schedules. Effective date of Compensation Plan to be either (a) July 1, 1961, or (b) effective date of county salary ordinance for 1961-62, whichever is applicable.

(W&IC 119.5, 119.6)

CALIFORNIA-SDSW-MANUAL

Effective 7/1/61

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CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATION
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

PUBLIC WELFARE WORKER-IN-TRAINING

Definition:

Under supervision of the State Department of Social Welfare to attend an accredited graduate school of social work under an educational grant plan.

Job Characteristics:

The class of Public Welfare Worker-In-Training is established for graduate students attending accredited graduate schools of social work.

Students remain in this class only for the period of their schooling. Prior to entrance into the program, students sign a legal agreement with the State Department of Social Welfare that upon completion of training they will accept employment in a public welfare program in a non-metropolitan county welfare department in California.

The positions in this class differ from other merit system classes in that they are primarily for the professional training of the person rather than for services to the agency.

Recruitment of students for this class will be from county welfare departments, colleges, or other recruitment sources where eligible candidates are available.

Minimum Qualifications:

1. Graduation from college, and
2. Eligibility for admission to graduate training in an accredited graduate school of social work in the United States, and

Knowledges and Abilities:

General understanding of human behavior and motivation;
ability in clear and effective written and oral expression;
analytical ability; potentialities for successful social

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(Pursuant to Government Code Section 11380.1)

work practice as evidenced by education achievement, work history, interest in people, ability to establish effective working relationships with groups and individuals, and ability to use experience in developing emotional maturity.

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These Regulations are designated to become effective JUN. 1 1961

CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATION...
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

W&IC 115, 116, 4605

EDMUND G. BROWN, GOVERNOR

STATE OF CALIFORNIA

DEPARTMENT OF SOCIAL WELFARE

J. M. WEDEMEYER, DIRECTOR

722 CAPITOL AVENUE, SACRAMENTO 14

April 21, 1961

DEPARTMENT BULLETIN NO. 606 (FISCAL)

To: COUNTY WELFARE DEPARTMENTS
COUNTY AUDITORS

Subject: VPMI Hospital Certifications
of Patient Status

During the recent Fiscal Institutes throughout the State, the problem of not receiving the county claims within the deadline date was discussed. The majority of the counties stated that the delay was due to the difficulty of obtaining the VPMI Hospital Certification of Patient Status (Form ABD 236-A and/or ABD 236-B) from the public medical institution early in the month.

In order to rectify this situation in counties where the problem exists, the following procedure may be employed by the counties:

1. Submission of VPMI claims to the SDSW may be based on data contained in monthly listings prepared by the Welfare Department. These data reflect the daily information received in the Welfare Department from the public medical institution.
2. When the actual VPMI Hospital Certification is received by the Welfare Department, it shall be checked to the listing prepared by the Welfare Department which they used for claiming purposes. Any discrepancies shall be corrected through the claim adjustment process on the following months claim.
3. The above procedure will be allowed only if there is on file in the Welfare Department the applicable Hospital Certifications for the preceding month, i.e., if a listing prepared by the Welfare Department for May 1961 is used instead of the actual Hospital Certification, the Hospital Certification shall be on file before a new listing for June 1961 is used.

Each county using the above procedures shall maintain adequate records of aid recipients entering and leaving the hospital so that claims submitted under these procedures will be as accurate as possible.

The provisions apply to payments to public medical institutions and claims for the month of May 1961.

These Regulations are designated to become effective JUN 1 1961

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CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATION
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

W&IC 115, 116

EDMUND G. BROWN, GOVERNOR

STATE OF CALIFORNIA

DEPARTMENT OF SOCIAL WELFARE

J. M. WEDEMEYER, DIRECTOR

722 CAPITOL AVENUE, SACRAMENTO 14

April 21, 1961

DEPARTMENT BULLETIN NO. 607 (STAT)

TO: COUNTY WELFARE DEPARTMENTS
COUNTY BOARD OF SUPERVISORS
COUNTY AUDITORS

Subject: Report on Aid to Needy Children
Cases Having a Money Management
Problem in July 1961,
Form Temp 280

In order to make a special report to the Department of Health, Education, and Welfare on certain characteristics of Aid to Needy Children families having a money management problem and also because it is necessary for the State Department of Social Welfare to have this information, this department is making a study of such cases as of the month of July 1961.

All counties shall prepare and transmit reports on all cases of this kind in accordance with "Instructions For Form Temp 280, July 1961, Report on Aid to Needy Children Cases Having a Money Management Problem in July 1961."

These reports require data for individual ANC cases on size of family, nature of problem, existence or absence of an administratively controlled plan, services provided the cases, nature of payment modification and items modified (if any), and total and modified grant.

Completed schedules shall be edited and corrected by county staff in accordance with editing instructions and sent to the Bureau of Statistical Reports, State Department of Social Welfare, 722 Capitol Avenue, Sacramento 14, California, to reach this office by August 31, 1961.

This bulletin shall cease to be effective on September 30, 1961.

Attachment

These Regulations are designated to become effective JUN 1 1961

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State of California
Department of Social Welfare

AID TO NEEDY CHILDREN CASES HAVING A MONEY MANAGEMENT PROBLEM
JULY 1961

Page _____ Of _____
Forward to Bureau of Statistical Reports
722 Capitol Avenue, Sacramento 14
By August 31, 1961

Report Prepared by _____

Date Report Prepared _____

County _____

Case Surname	State Number	Number of Eligible ANC Children in Case	Nature of Problems (Enter Codes)	Is There an Administratively Controlled Plan? (Check)		Services Provided (Enter Codes)	Payment Modification		Grant for July 1961 (Cait Cents)		
				Yes	No		Nature of Modification (Enter Codes)	Items Modified (Enter Codes)	Total	Amount Modified	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	
									\$	\$	
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											

Form Temp 280, July 1961

CODES AND INSTRUCTIONS ON REVERSE SIDE

These Regulations are designated to become effective

JUN 1 1961

CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATION
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

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INSTRUCTIONS FOR FORM TEMP 280, JULY 1961, REPORT ON AID TO NEEDY CHILDREN CASES HAVING A MONEY MANAGEMENT PROBLEM

General: The basis for this study is Manual Section C-222.50 (Regulation) of the Manual of Policies and Procedures. Using one line for each case, make a report for each ANC Family Group case which in July 1961 is believed by the worker to have a "money management" problem, as defined in that section. If more than one family budget unit having the same state case number has money management problems, report each family budget unit on a separate line, adding suffixes "A," "B," "C," etc., to the state number.

It is expected that there will be many families known to have money management problems but whose grant is not modified. For these families enter "0" in columns 8, 9, and 11. No column should be left blank for any family.

Completed and edited schedules should reach the Bureau of Statistical Reports, State Department of Social Welfare, 722 Capitol Avenue, Sacramento 14, California, not later than August 31, 1961. Schedules may be completed by hand if care is taken to write legibly.

Instructions for Columns:

- (1) **Case Surname** - Enter the surname by which the family is commonly known to the county welfare department. This entry will be helpful in identifying and communicating about families.
- (2) **State Number** - Enter the state case number by which the family is identified in county records. If more than one family budget unit with the same case number is reported on, distinguish these with the suffixes, "A," "B," "C," etc.
- (3) **Number of ANC Children in Case** - Enter the number of children in the family budget unit who are eligible for ANC.
- (4) **Nature of Problems (enter codes)** - Enter each letter from the list below designating a money management problem which the family budget unit is known to have. If all these problems are present, the entry will be "A, B, C, D, E." This list is from Manual Section C-222.50, Item 2:

- A. Inability to plan and spread necessary expenditures over the usual assistance planning period.
- B. Overbuying and the excessive use of credit, resulting in diversion of funds needed for current food, household operations, and child care purposes.
- C. Persistent or deliberate failure to meet obligations for current rent, food, school obligations and similar essentials while making expenditures for other less essential purposes or unrelated to present or future needs.
- D. Repeated evictions, attachments and levies against current income or earnings.
- E. The client has requested money management services.

- (5) **Is there an Administratively Controlled Plan? (Yes or No)** - Answer this question according to the specifications in Item 4 of Manual Section C-222.50, which appear below.
- (6) **Section C-222.50, which appear below.**

An Administratively controlled plan is one which:

- a. Is documented.
- b. Sets forth the agency's conclusions as to the factors contributing to the situation.
- c. Establishes the frequency and nature of contacts and the agency actions to be taken.
- d. Establishes the responsibility for implementing and carrying out the necessary agency actions.
- e. Reflects the results achieved by carrying out the plan and any modifications resulting from experience as the plan progresses.
- f. Is reviewed and revised or reconfirmed at intervals not to exceed three months.

In instances where the maximum potential for improvement has been reached and can be maintained only with the help of long-term payment modifications, the reevaluation period may be extended to six months.

- g. Is subject to administrative review and approval.

- (7) **Services Provided (enter codes)** - Enter each letter from the list below designating a service which was given the family budget unit during July 1961. For example, if services of the first three types were given in July 1961, the entry will be "A, B, C." If no services were given in July 1961, enter "0." Note that if "g" is entered, Columns 8, 9, and 11 must not have "0" entries. This list is from Manual Section C-222.50, Item 5:

- A. Help and advice with budget planning, and planning of expenditures.
- B. Consultation with creditors and/or participation in bringing the principals together for the purposes of achieving a mutual agreement.
- C. A debt adjustment service.
- D. Arrangements with other agencies or individuals for referrals.
- E. Arranging for participation in group counseling or guidance.
- F. Money payments at intervals of one or two weeks within the month.
- G. Modified payments.
- H. No services provided in July 1961.

- (8) **Payment Modification - Nature of Modification (enter codes)** - Enter each letter from the list below, designating a form of payment modification which was used for the family budget unit during July 1961. For example, if all four forms of modification were used, the entry will be "A, B, C, D." If there was no payment modification in July 1961, enter "0" and also enter "0's" in Columns 9 and 11. This list is from Manual Section C-222.50, Item 6:

- A. Modified money payments to the payee, made with the requirement that they are to be spent for a particular item or paid to a particular vendor.
- B. Payments made jointly to the client and vendor for one or more items.
- C. Payments made to vendors for one or more items.
- D. Payments in kind.
- E. No payment modification in July 1961.

- (9) **Payment Modification - Items Modified (enter codes)** - Enter each letter from the list below, designating an item of need for which the July 1961 payment to the family budget unit was modified by one or more of the methods listed in (8), above. If there was no payment modification, enter "0." If all items of need were affected by the modification or no item was singled out as being specifically modified, enter all letters, "A, B, C, D, E."

- A. Food.
- B. Clothing.
- C. Housing.
- D. Utilities.
- E. Other.

0. No payment modification in July 1961.

- (10) **Grant for July 1961 - Total** - Enter the total assistance payment to the family budget unit for the month of July 1961. To the extent possible, include supplemental payments and any adjustments for repayments, cancellations, etc. Eliminate cents by rounding to the nearest dollar.

- (11) **Grant for July 1961 - Amount Modified** - Enter the total amount of all modified assistance payments to the family budget unit for the month of July 1961. Eliminate cents by rounding to the nearest dollar. If payments are not modified, enter "0." Note: Unrestricted multiple payments are not to be considered modified payments for purposes of this report.

Pretransmittal Edits

In the interests of time and accuracy all schedules should be edited before sending to Sacramento. Schedules found in error should be returned to the originator for correction.

The edits are as follows:

1. No column may be left blank. If the answer is "none," "0" should be entered.
2. Column 1 - 4, inclusive, and Column 10, must always have a significant entry, i.e., they must not be "0."
3. Column 7, 8, and 9 must have one or more codes entered, or "0."
4. If Column 8 is "0" Column 9 and 11 must be "0."
5. If Column 8 is not "0" Column 9 and 11 must not be "0."
6. The entry in Column 11 may be as great as the entry in Column 10, but must not be greater.
7. If one of the codes entered in Column 7 is "G," Columns 8, 9, and 11 must not be "0."
8. Check each entry for legibility.

FACE SHEET
**FILING ADMINISTRATIVE REGULATIONS
 WITH THE SECRETARY OF STATE**
 (Pursuant to Government Code Section 11380.1)

RECEIVED FOR FILING

JUN 1 1961

Division of Administrative Procedure

ENDORSED

APPROVED FOR FILING
 (GOV. CODE 11380.2)

JUN 1 1961

Division of Administrative Procedure

Copy below is hereby certified to be a true and correct copy of regulations adopted, or amended, or an order of repeal by:

State Department of Social Welfare

(Agency)

Dated: May 31, 1961

By:

Director

(Title)

FILED

In the office of the Secretary of State
 of the State of California

JUN 1 1961

At 10:00 o'clock a.m.

FRANK M. JORDAN, Secretary of State

By: *John C. Butler*
 Assistant Secretary of State

DO NOT WRITE IN THIS SPACE

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B-198 EXPENSES IN CONNECTION WITH EYE OR
 NEUROPSYCHIATRIC EXAMINATIONS

B-198

There is to be no expense to the applicant, recipient or appellant for any eye and/or neuropsychiatric examination required by the SDSW.

The maximum fee, which is considered proper county administrative expense, for an eye examination and report by a physician is \$16. Exception: In cases of conflict in eye examination reports where an additional examination and report is required, a fee of \$20 is a proper administrative expense.

The maximum fee, which is considered proper county administrative expense, for an eye examination and report by an optometrist is \$15.

A reasonable fee for a neuropsychiatric examination, if required, may be considered an allowable county administrative expense. (See Sec. B-192.05, Neuropsychiatric Examinations.)

Necessary transportation expense to secure required eye and/or neuropsychiatric examinations is allowable administrative expense. (See Appendix Fiscal Manual Sections, Sec. F-875)

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These Regulations are designated to become effective July 1, 1961.

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Regulations PREVENTION OF BLINDNESS B-303.2

B-303.2 TYPES OF TREATMENT B-303.2

The following list indicates the types of treatment which may be authorized by the SDSW and the maximum fee which may be allowed under the program.

FEE SCHEDULE

Cataract, Needling or Discission, operation for.	\$ 50.00
Cataract, operation for (to include all postoperative care within 90 to 120 days following surgery, as well as final report and refraction).	175.00
Cataract, operation for (to include up to 15 days postoperative care and consultation if requested by local eye physician within 120 postoperative days).	115.00
Cataract, local postoperative care for balance of postoperative period including a refraction and report by an eye physician (ophthalmologist) other than the operating surgeon	60.00
Corneal Surgery - Nonpenetrating (to include all postoperative care within 90 to 120 days following surgery)	150.00
Corneal Surgery - Penetrating (to include 3 mos. postoperative care)	250.00
Ectropion, operation for	50.00
Entropion, operation for	50.00
Enucleation of Eye, if necessary to preserve vision in remaining eye	75.00
Glaucoma, surgery for (other than simple Iridectomy)	90.00
Iridectomy, Simple Iridectomy.	75.00
Lacrimal Sac, excision of, or Dacryocystotomy.	50.00
Pterygium, removal of, or other external eye surgery up to	40.00
Retinal Detachment, correction of, if required in postsurgical cases under Prevention of Blindness program.	150.00
Retinal Detachment occurring outside of the Prevention of Blindness program may be included upon the recommendation of the State Ophthalmologist.	
Each surgery fee except as indicated includes up to 15 days postoperative care.	
Office visits - \$5.00 each, following 15 days postoperative period (except if surgery fee includes postoperative observation)	
Diagnostic examination including a refraction and report by an eye physician (ophthalmologist) (when surgery not performed)	16.00
Fee for diagnostic examination included in surgery fee when surgery follows.	

PHYSICAL EXAMINATION

Physical examination to determine feasibility for eye surgery.	10.00
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TREATMENT ONLY
(No surgery involved)

Observation and Report	5.00
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(Continued)

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

B-303.2

PREVENTION OF BLINDNESS

Regulations

B-303.2 (Continued)

B-303.2

REFRACTIONS AND EYEGLASSES

If a physician or optometrist prescribes eyeglasses, the cost of re-
fractions and of eyeglasses, not to exceed the following maxima, are allowable:

Refraction	-	\$15.00
Bifocal lenses (other than cataract)	- each lens	10.00
Single vision lenses (other than cataract)	- each lens	5.00
Bifocal cataract lenses	- each lens	20.00
Single vision cataract lenses	- each lens	10.00
Tinted lenses	- additional for each lens	2.00
Prism	- additional for each lens	2.00
Frames	-	10.00

(Sales tax is added to the above maxima.)

Only one pair of glasses is allowed except if correction for both
reading and distance vision is required and two pairs of glasses are pre-
scribed by a physician or optometrist because the recipient's physical condition
prevents the use of bifocal lenses.

OTHER COSTS

Consultation or anesthetist service, if required	As charged
Hospital items	As charged
Boarding home items, if required	As charged
Miscellaneous items, if required	As charged
Transportation items, if required.	As paid
Personal items, such as shaves, haircuts, telephone calls, personal service, etc.	As paid
	Not to exceed an average of \$1.00 per day for the time the patient is in the hospital or nursing home.

Since glaucoma is a condition which frequently requires emergent action,
treatment should be provided through local medical facilities. If no local re-
sources are available, the SDSW may provide glaucoma treatment and/or surgery.

If medical complications not directly related to the eye treatment or
surgery should develop while a person is under care of SDSW, only emergency
measures can be authorized until the individual or county arranges for
necessary care.

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

MC-031.1 SERVICES AVAILABLE WITHOUT PRIOR AUTHORIZATION

MC-031.1

- A. Home and/or office visits from or to practitioners (other than dentists or podiatrists) to a limit of three such visits for any one illness, or within 90 days from the first visit, whichever is less.
- B. Dental services, including extractions, required for the relief of pain, or the elimination of acute infection. For OAS recipients only, denture repair and adjustment.
- C. Drugs and Medical Supplies:

Prescribed drugs and medical supplies are to be allowed in accordance with a Formulary, formulated and promulgated by the Director of the State Department of Social Welfare, within the specific limitations provided. The Drug Formulary shall meet the following conditions and limitations:

1. Be limited to those necessary to save or extend life and to alleviate or prevent suffering or severe discomfort;
2. Be limited to those of proved efficacy;
3. With respect to drugs designed to treat specific diseases, it must be restricted to cases suffering from such diseases;
4. Shall not include combinations of doubtful necessity or time-release preparations;
5. Shall include price ceilings on drugs available at greatly varying cost in order that expensive brand name products will not be purchased when equally effective less expensive chemical equivalents are available.

In developing the specific list of drugs and medical supplies the Director shall be guided by the advice and recommendations of the Advisory Committee on Medical Care.

Drugs may be administered or prescribed by licensed physicians, dentists or podiatrists.

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These Regulations are designated to become effective JUL 1 1961

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

MC-031.1

SCOPE AND LIMITATIONS

Regulations

MC-031.1 (Continued)

MC-031.1

Prescriptions should be confined to quantities necessary for the estimated duration of the illness. Where medication is constantly prescribed for the chronically ill, the quantity prescribed should be the most economical amount from the point of view of cost. Expensive proprietary items should not be prescribed when significantly less expensive items would be equally effective.

Prescriptions shall be written on forms prescribed by the SDSW and shall be filled within seven days from the date of issue. No prescription shall be refillable.

Practitioners who do not comply with the rules and procedures contained in this manual shall not use prescription blanks furnished by the SDSW.

- D. Laboratory services for urinalysis and blood counts.
- E. Laboratory and X-ray services as prescribed by the practitioner in an emergency.
- F. Emergency surgery not requiring hospitalization under accepted medical standards.
- G. Services of visiting nurse associations or nurses in public agencies rendering home nursing to a maximum of five visits for any one illness.
- H. Physical examinations of children receiving Aid to Needy Children who are being placed away from their own parents in foster homes or institutions.
- I. Refractions for Old Age Security Recipients and necessary repairs to eye appliances.

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CALIFORNIA-SDSW-MANUAL-MC

Rev. 303 replaces Rev. 279

Effective 3/1/61

CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATIONS
 WITH THE SECRETARY OF STATE**
 (Pursuant to Government Code Section 11380.1)

Regulations

SCOPE AND LIMITATIONS

MC-031.6

MC-031.6 SERVICES AVAILABLE WITH
 PRIOR AUTHORIZATION

MC-031.6

I. Services for which prior authorization may be waived (MC-053.50)

- A. Home and/or office visits from or to practitioners (other than dentists and podiatrists) in excess of three such visits for any other illness or beyond the 90th day from the first visit.
- B. Any service rendered by podiatrists.
- C. (Deleted 7/1/61)
- D. Elective laboratory services other than urinalysis and blood counts.
- E. Elective radiological and outpatient radiotherapy services.
- F. Services of private nurses, visiting nurse associations, or nurses in public agencies rendering home nursing in excess of five visits for any one illness.
- G. Dental care for children under 13 years of age as necessary to prevent tooth loss and maintain dental health. During the period beginning July 1, 1961, and ending December 31, 1961, such care may also be given to children aged 13 through 17 years.
- H. Complete histories and physical examinations by physicians.
- I. Services of physical therapists as prescribed by physicians.
- J. For OAS recipients all essential dental care necessary to restore and maintain adequate dental health pursuant to standards established by the Director of the SDSW.
- K. Elective office surgery.

II. Services for which prior authorization may not be waived.

- A. Services of rehabilitation facilities meeting the standards of the Vocational Rehabilitation Service.
- B. For Old Age Security recipients only, eye appliances listed in the Schedule of Maximum Allowances. (MC-045.1)
- C. For OAS recipients only, medical and osteopathic services and laboratory tests necessary for a comprehensive annual health evaluation. (Effective 7/1/61)
- D. For OAS and ATD recipients only, care, services, supplies, and equipment determined by a certified rehabilitation facility as necessary during the period the rehabilitation plan is in effect. (See MC-018)

CALIFORNIA-SDSW-MANUAL-MC

Rev. 397 replaces Rev. 342

Effective 7/1/61

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CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATION...
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

MC-033

SCOPE AND LIMITATIONS

Regulations

MC-033

DURATION OF PRIOR AUTHORIZATION FOR ALL RECIPIENTS

MC-033

A prior authorization shall be valid until notice of cancellation is received from the county welfare department.

In case of dental care a period of 10 days from date of cancellation will be allowed for completion of minimum work necessary.

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CALIFORNIA-SDSW-MANUAL-MC

Rev. 398 replaces Rev. 238

Effective -7/1/61

CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

MC-040.1

SCHEDULE OF MAXIMUM ALLOWANCES

Regulations

MC-040.1 MEDICAL SERVICES

MC-040.1

VISITS AND EXAMINATIONS

MAXIMUM
CHARGE

004	HOME VISIT, REQUESTED AND MADE BETWEEN 11 P.M. AND 8 A.M. (\$3 EACH ADDITIONAL MEMBER OF HOUSEHOLD, MAXIMUM TOTAL ANY ONE VISIT \$16)	\$10.00
006	ROUTINE OFFICE VISIT	4.00
007	ROUTINE VISITS TO PRIVATE ABODES, PRIVATE INSTITUTIONS, NURSING HOMES, BOARDING HOMES (\$3 FOR EACH ADDITIONAL PERSON VISITED)	6.00
008	MILEAGE PER MILE, ONE WAY, BEYOND RADIUS OF 10 MILES OFFICE OR HOME	.80
011	OFFICE VISIT, NOT OF ROUTINE NATURE, REQUIRING HISTORY AND EXAMINATION TO DETERMINE DIAGNOSIS AND TREATMENT. THIS INCLUDES PHYSICAL EXAMINATIONS FOR CHILDREN PRIOR TO FOSTER HOME PLACEMENT AND GENERAL PHYSICAL EXAMINA- TIONS FOR ADULTS ON WHOM NO RECENT RECORD OF HEALTH CONDITION IS AVAILABLE	8.00
029	OFFICE VISIT OF GREATER THAN ROUTINE NATURE REQUIRING ABOVE THE USUAL AMOUNT OF EFFORT, SKILL AND TIME, GENERALLY OVER 20 MINUTES. THE VISIT MAY RELATE TO EVALUATION AND EXAMINATION OF ADDITIONAL SUBJECTIVE AND OBJECTIVE MANIFESTATIONS OF A DISEASE PROCESS NOT PREVIOUSLY EVALUATED; EXTENDED DISCUSSION OF A SERIOUS MEDICAL CONDITION; A DETAILED PLAN OF TREAT- MENT FOR DISEASES SUCH AS DIABETES AND ARTHRITIS; LENGTHY INTERPRETATION OF LABORATORY OR X-RAY PRO- CEDURES, NEUROLOGICAL TESTS; OR OTHER UNUSUAL MEASURES	6.00
030	HOME VISIT NECESSITATING PROFESSIONAL CARE OVER AND ABOVE ROUTINE HOME VISIT	10.00
031	HOME VISIT NECESSITATING PROFESSIONAL CARE OVER AND ABOVE ROUTINE HOME VISIT, 11 P.M. TO 8 A.M.	12.00
032	PROLONGED DETENTION WITH PATIENT IN CRITICAL CONDITION, PER HOUR	16.00
034	OFFICE VISIT NECESSITATING RESURVEY OF PATIENT AS A WHOLE	8.00

(Continued)

CALIFORNIA-SHSW-MANUAL-MC

Rev. 401 replaces Rev. 119

Effective 7/1/61

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CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
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(Pursuant to Government Code Section 11380.1)

Regulations SCHEDULE OF MAXIMUM ALLOWANCES MC-040.1
MC-040.1 (Continued) MC-040.1

Pro. No.	Procedure	Maximum Charge	Pro. No.	Procedure	Maximum Charge
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SPECIAL MEDICAL PROCEDURES

The following items are included in the schedule to be used in cases which appear to be of a serious or complicated nature requiring additional time and special study.
Written reports shall be furnished upon request to validate the performance of the described services which involve more care than can be provided by the ordinary office or home visit.
All of the following require prior authorization except in an emergency.

026 Consultation on referral for given system not requiring complete examination - office or home - with copy of report to county welfare department----- \$12.00
027 Consultation on referral requiring complete examination - office or home - with copy of report to county welfare department----- 28.00
028 Complete history and physical examination - office or home - with report----- 20.00

ALLERGY

History and Physical Examination covered by 011-028.
Laboratory and X-rays covered by Pathology and Radiology Schedule.

ALLERGY TESTING

Allergy tests as an aid in the diagnosis of disease if read and interpreted by a physician. All allergy testing requires prior authorization.
The fee to be based on the type of test as well as the number performed, but with a maximum fee allowable for each disease.

ALLERGY TESTING (Continued)

Where two or more allergic diseases are present only one fee will be allowed, that fee to be that of the disease with the highest unit value.

Unit Fee by Type and Number of Tests Performed. (This includes the observation of the tests.)

102	Scratch or puncture tests, per 10 tests Minimum--\$4-----	\$ 4.00
103	Intradermal tests, per 10 tests Minimum--\$4-----	6.00
104	Patch tests, per one test Minimum--\$4-----	.80
105	Direct ophthalmic tests, per one test Minimum--\$4-----	1.60
106	Direct nasal test, per one test Minimum--\$4-----	1.60
107	Passive transfer tests, per 10 tests Minimum--\$4-----	12.00
111	Allergic Rhinitis--seasonal-----	28.00
151	Conjunctivitis--seasonal-----	28.00

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CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATION...
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

MC-010.2 (Continued)

MC-010.

Pro. No. Procedure Maximum Charge

Pro. No. Procedure Maximum Charge

SURGERY (Continued)

EYE (Continued)

EYE

5437	Peripheral fields, complete	\$8.00
5443	Paracentesis of cornea (keratocentesis)	40.00
*5445	Removal of foreign body from surface of cornea	6.00
5448	under slit lamp	12.00
5457	Pterygium	80.00
*5465	Curettage and cauterization of corneal ulcer	20.00
*5466	Iontophoresis of corneal ulcer	20.00
5496	Aspiration of anterior chamber	16.00
5511	Air injection into anterior chamber for chronic glaucoma	60.00
5515	Irrigation and air injection into anterior chamber for chronic glaucoma	60.00
5671	Orbital injection of alcohol for hemorrhagic glaucoma--or intractable pain	40.00
*5691	Blepharotomy with drainage of abscess of eyelid	8.00
*5692	with drainage of Meibomian glands; hordeolum (stye)	8.00
5702	Blepharectomy incision or excision of Meibomian glands (chalazion), single	20.00
5707	Excision of lesion of eyelid, malignant (See 0260 to 0296EVS)	20.00
5712	Epilation, electrolytic	20.00
5717	Excision of xanthoma (See 0260 to 0296EVS)	20.00
*5728	Cautery puncture for entropion or ectropion	20.00
5731	Blepharorrhaphy: suture of eyelid (See 0265 to 0267.)	

5734	Tarsorrhaphy: suture of tarsal cartilage (See 0265 to 0267.)	
5737	Canthorrhaphy: suture of palpebral fissure of canthus (See 0265 to 0267.)	
*5741	Removal of foreign body from surface of conjunctiva	\$4.00
*5742	embedded in conjunctiva	8.00
*5743	Suture of conjunctiva	12.00
*5751	Biopsy of conjunctiva	20.00
*5753	Excision of lesion of conjunctiva: cyst	20.00
5801	Drainage of lacrimal gland (abscess)	40.00
5821	Catheterization of lacrimonasal duct, initial	40.00
*5835	Closure of punctum by cautery	16.00
*5841	Dilation of punctum	8.00
*5843	Probing of lacrimonasal duct, initial	12.00
*5844	subsequent	6.00

EAR

*5901	Drainage of abscess of auricle	8.00
*5903	Drainage of hematoma of auricle	8.00
*5905	Drainage of abscess of external auditory canal	8.00
*5911	Biopsy of ear	8.00
*5931	Otoscopy with removal of foreign body in external auditory canal	8.00
5955	Catheterization of Eustachian tube	6.00
*5961	Myringotomy: tympanotomy; plicotomy	8.00

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These Regulations are designated to become effective.....

CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

MC-040.4

SCHEDULE OF MAXIMUM ALLOWANCES

Regulations

MC-040.4 (Continued)

MC-040.4

Pro. No.	Procedure	Maximum Charge	Pro. No.	Procedure	Maximum Charge
PATHOLOGY (Continued)			MISCELLANEOUS (Continued)		
TISSUES (Continued)			8956	Basal metabolic rate	\$4.80
8911	culture for bacteria screening	\$4.00	8957	Electrocardiogram, with interpretation and report	10.00
8912	culture for bacteria, definitive	8.00	8958	without interpretation and report	4.00
8917	Cytologic study (Papanicolaou smear)	10.00	8959	interpretation and report only (tracing not done by interpreting physician)	6.00
8918	gastric or pepsin	16.00	8960	exercise test, with interpretation and report	14.00
URINE			8967	Urinary 17-ketosteroids	10.00
8930	Routine chemical, qualitative	.80	8968	11-oxysteroids	12.00
8931	Quantitative sugar	1.20	8969	gonadotropins	12.00
8932	Routine microscopic	.80	8970	Residual air determination	By report
8933	Bence-Jones protein	.80	8971	Bronchspirometry (See 2126.)	20.00
8934	Complete routine (chemical and microscopic)	1.60	8972	Exclusion test for pheochromocytoma (Regitine, etc.)	6.00
8935	Quantitative functional (Addis)	4.00	8973	Direct smear without stain	1.60
8936	Concentration and dilution tests	1.60	8974	Miscellaneous smear for bacteria with stain	2.40
8937	Sugar fermentation	.80	8976	Miscellaneous culture for bacteria screening	4.00
8938	Phenosulfonphthalein	4.00	8978	Miscellaneous animal inoculation for bacteria	10.00
8939	Porphyryns, qualitative	4.00	8979	Miscellaneous culture for bacteria definitive	8.00
8940	quantitative	10.00	8983	Vital capacity	2.40
8941	Smear for bacteria	2.40	8984	Muscle appraisal, complete (galvanic)	15.00
8942	Porphobilinogen	2.40	8987	Skin tests with bacterial extracts (each) (Brucella, Frei, Tuberculin, etc.)	3.20
8943	Culture for bacteria screening	4.00	8988	Venous pressure	4.00
8944	Lead, quantitative	12.00	8989	Circulation time	4.00
8945	Culture for bacteria, definitive	8.00	8991	Stone analysis, qualitative	4.00
8946	Quantitative calcium (Sulkowitch)	1.20	8992	quantitative	12.00
8947	Bile pigments	1.20	8994	Transudates and exudates, microscopic (See 8903)	
8948	Quantitative chemical examination (see Blood)		8995	Culture screening	4.00
8949	24-hour calcium	4.00	8996	definitive	8.00
MISCELLANEOUS			8997	Animal inoculation	10.00
8950	Electroencephalogram	20.00	8998	Chemical (see Blood)	
8951	Antibiotic sensitivity, per antibiotic (pyrogenic)	1.60	8999	Ventilation studies, complete (respirometer), including spiogram, timed vital capacity, maximal breathing capacity, with interpretation and report	12.00
8953	Autogenous vaccine	12.00			
8954	Audiometer testing, any method	6.00			
8955	Barany vestibular test	8.00	9000	Injections, medications, and medical supplies, at cost	varied

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**CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE**
(Pursuant to Government Code Section 11380.1)

MC-042

SCHEDULE OF MAXIMUM ALLOWANCES

Regulations

MC-042 DENTAL SERVICES

MC-042

Code No.	Procedure	Maximum Charge	Code No.	Procedure	Maximum Charge
<u>VISITS AND EXAMINATION (010-099)</u>			<u>EXTRACTIONS (200-299)</u>		
010	Examination and completion of treatment planning form	\$6.00	200	Single with local anesthesia	\$5.00
020	Office visit for treatment and observation of injuries to teeth and supporting structure, other than placement of steel crown, pulpotomy, etc.	3.00	201	Each additional tooth	4.00
030	Professional visits to bedside	6.00	230	Impacted teeth	15.00-40.00
040	Special consultation fee, necessity to be shown	10.00	<u>DRUGS (300-399)</u>		
050	Prophylaxis treatment (to include scaling and polishing teeth)	6.00	Penicillin injection:		
060	Topical application of sodium fluoride (series of four treatments)	20.00	300	300,000 u. aqueous procaine	2.00
070	Periodontia treatment	6.00	301	600,000 u. aqueous procaine	3.00
075	Removal of hypertrophied gingival areas (polyps)	3.00	302	Bicillin 1,200,000 u.	4.00
080	Emergency treatment, palliative	4.00	<u>ANESTHESIA (400-499)</u>		
090	AgNO ₃ application. Fluoride paste or other medication to a tooth surface to inhibit caries or to desensitize the area	2.00	400	Anesthetics: General	10.00
095	Vitality test with pulp tester	3.00	<u>ROOT CANAL THERAPY (500-599)</u>		
<u>RADIOGRAPHY AND PATHOLOGY (100-199)</u>			Pulpal therapy:		
110	Single film	2.00	500	Pulp capping	5.00
111	Additional films (up to and including a total of 13 films), each	1.00	501	Therapeutic pulpotomy	12.00
112	Entire denture series consisting of at least 14 films	10.00	502	Vital pulpotomy	10.00
113	Intraoral, occlusal view, maxillary or mandibular, each	2.00	511	Extirpation of pulp, treatment, filling root canal, roentgenogram	25.00
114	Superior or inferior maxillary, extraoral, one film	5.00	530	Apicoectomy	25.00
115	Superior or inferior maxillary, extraoral, two films	7.50	<u>RESTORATIVE DENTISTRY (600-699)</u>		
160	Microscopic examination	5.00	Amalgam fillings:		
			600	Cavities involving one tooth surface	6.00
			601	Cavities involving two tooth surfaces	9.00
			602	Cavities involving three or more tooth surfaces	12.00
			Gold Fillings or inlays:		
			635	Cavities involving one tooth surface	18.00
			636	Cavities involving two tooth surfaces	28.00
			637	Cavities involving three or more tooth surfaces	32.00

(Continued)

CALIFORNIA-SDSW-MANUAL- MC

Rev. 404 replaces Rev. 16

Effective 7/1/61

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**CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE**
(Pursuant to Government Code Section 11380.1)

Regulations			SCHEDULE OF MAXIMUM ALLOWANCES			MC-042
MC-042 (Continued)						MC-042
Code No.	Procedure	Maximum Charge	Code No.	Procedure	Maximum Charge	
Gold fillings or inlays: (Continued)			Repairs, crowns and bridges:			
640	Silicate cement filling	\$7.00	690	Replace broken pin facing with Bryant repairs	\$10.00	
645	Acrylic or plastic filling	9.00	691	Replace broken pin facing with Steele's repairs	12.00	
Crowns:			692	Replace broken Steele's facing where post backing is intact	6.00	
650	Acrylic jacket	55.00	693	Replace broken Steele's facing where post on backing is broken	12.00	
652	Porcelain jacket	60.00	<u>PROSTHETICS</u> (700-799)			
Gold:			Dentures:			
With heavy cast cusps or all cast:			700	Full upper or lower: Acrylic	100.00	
660	Molar	35.00	701	Partial upper or lower without clasps: Acrylic	62.00	
661	Bicuspid	35.00	702	Partial upper or lower with two gold or chrome cobalt alloy clasps: Acrylic	105.00	
662	Cuspid or incisor	35.00	703	Partial lower with gold or chrome cobalt alloy lingual bar and two clasps: Acrylic	125.00	
663	Three-quarter, any tooth	35.00	704	Partial upper with gold or chrome cobalt alloy palatal bar and two clasps: Acrylic	125.00	
665	One- or two-piece, with swaged cusps	25.00	705	Clasps, additional gold or chrome cobalt alloy	18.00	
Stainless steel:			720	Denture adjustment	3.00	
670	Primary tooth	15.00	Repairs, dentures, acrylic:			
671	Permanent tooth	17.50	790	Broken denture, repairing (no teeth involved)	10.00	
Bridge work:			791	Repair broken denture - teeth involved:		
Abutments (see Crowns and Inlays)				First tooth	15.00	
Pontics:				Each tooth, additional	5.00	
680	Cast gold, posterior (sanitary)	25.00	792	Replacing broken teeth on denture only:		
Gold and porcelain:				First tooth	10.00	
681	Steele's facing type	30.00		Each additional tooth	5.00	
682	Tru-Pontic type	35.00	794	Adding teeth to partial denture to replace extracted natural teeth:		
Removable:				First tooth	18.00	
683	One-piece casting, gold or chrome cobalt alloy clasp attachment (all types)	23.00	(Continued)			
684	Pontic (including tooth)	23.00				
Recementing:						
685	Inlay	3.00				
686	Crown	3.00				
687	Bridge	7.00				

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

MC-042 SCHEDULE OF MAXIMUM ALLOWANCES Regulations

MC-042 (Continued) MC-042

Code No. Procedure Maximum Charge

Adding teeth to partial denture to replace
extracted natural teeth: (Continued)

Each additional tooth \$5.00
796 Replacing clasp on denture,
clasp intact 10.00
797 Replacing broken clasp on
denture with new clasp 20.00

SPACE MAINTAINERS (800-899)

800 Fixed space maintainer 50.00
Removable acrylic space maintainer:
801 a. With stainless steel round
wire rests only 40.00
802 b. Stainless steel clasps and/or
activating wires in addition,
per wire or clasp 5.00
820 c. Office visit for: Observation,
adjustment, and activation,
per visit 3.00
803 d. Study models 5.00
810 Removable inhibiting appliance
to correct thumbsucking 40.00
821 Office visit for: Observation,
adjustment, and activation,
per visit 3.00
832 Fixed or cemented inhibiting
appliance to correct thumbsucking 40.00
822 Office visit for: Observation,
adjustment, and activation,
per visit 3.00

FRACTURES AND DISLOCATIONS (900-999)

900 Treatment of simple fracture of the
the maxilla 75.00
902 Treatment of simple fracture of
the mandible 75.00
904 Treatment of compound or comminuted
fracture of the maxilla 150.00
906 Treatment of compound or comminuted
fracture of the mandible 150.00
910 Treatment of luxation (dis-
location) of the mandible 5.00

CALIFORNIA-SDSW-MANUAL-MC Rev. 415 replaces Rev. 17 Effective 7/1/61

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CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

MC-045.1 REFRACTIONS AND EYE APPLIANCES

MC-045.1

For OAS recipients only, if a physician or optometrist recommends the use of eye appliances, the cost of refractions and of eye appliances is allowed not to exceed the maxima listed below. Payment may be made only for those eye appliances listed below.

More than one type of glasses is permitted if correction for both reading and distance vision is required and two pairs of glasses are recommended by a physician or optometrist because the recipient's physical condition prevents use of bifocal lenses.

Lenses must be of a quality at least equal to Tillyer, Orthogon or Univis.

Pro. No.

9505	Refraction - Initial	\$15.00
9506	Refraction - Follow-up, same practitioner, within six months	10.00
9507	Eye evaluation, with refraction, by an eye physician	16.00
9510	Bifocal lenses (other than cataract) - each lens	10.00
9511	Single vision lenses (other than cataract) - each lens	5.00
9512	Bifocal cataract lenses - each lens	20.00
9513	Bifocal cataract lenses - each lens - Lenticular - Rose tint	27.50
9514	Bifocal cataract lenses - each lens - Lenticular - balance - Rose tint	13.75
9515	Single vision cataract lenses - each lens	10.00
9516	Single vision cataract lenses - each lens - Lenticular - Rose tint	13.75
9518	Tinted lenses - additional for each lens	2.00
9519	Prism - additional for each lens	2.00
9521	Trifocals (replacement only) other than cataract - per lens	15.00
9522	Slab-off (other than cataract) - additional for each lens	8.50
9530	Frames	10.00
	Artificial eyes	
9540	Plastic, stock - each	35.00
9541	Glass - each	15.00
9545	Corneal lenses for correction of keratoconus or other pathological conditions of the cornea wherein useful (i.e., 20/80) vision cannot be obtained with regular lenses - per pair	100.00
9549	Repairs Cost is to be allowed in accordance with local community practice, not to exceed a reasonable amount as determined by the county.	

(Sales tax, where applicable, is added to the above maxima.)

These Regulations are designated to become effective JUL 1 1961

DO NOT WRITE IN THIS SPACE

**CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE**
(Pursuant to Government Code Section 11380.1)

Regulations

SCHEDULE OF MAXIMUM ALLOWANCES

MC-046

MC-046

SCHEDULE OF MAXIMUM ALLOWANCES, DRUGS AND MEDICAL SUPPLIES

MC-046

No payment will be made for drugs or medical supplies except for those items set forth in the drug formulary.

The pharmacist shall dispense the lowest cost item he has in stock meeting the requirements of the practitioner as shown on the prescription form.

All prescriptions for narcotics shall be accompanied by the required federal prescription form. No surcharge will be allowed for narcotic nor hypnotic prescriptions.

Prescriptions must be filled within seven days from the date of issue and are not refillable.

The maximum allowances for drugs and medical supplies shall not exceed the lesser of the usual retail selling price or the following amounts:

1. Drugs which may not be dispensed by the druggist under federal or state laws except upon prescription by a physician, dentist or chiropodist:

- A. Noncompounded Drugs

1. The wholesale cost of the drug may be increased by an amount not to exceed 50 percent, plus
2. A single prescription fee of \$1.15 is allowed for each prescription.

- B. Compounded Drugs

1. Any prescription containing two or more ingredients (not including therapeutically inert adjuncts), mixed by the pharmacist at time of dispensing, is a compounded prescription.
2. The cost of any prescription is the sum of the costs of the amounts of the ingredients actually dispensed plus the cost of the container.
3. The cost of materials is to be based on the wholesale cost.
4. The time-cost schedule (see Item 7) provides a professional fee for compounding, and has been calculated on the basis of \$5.75 per hour.
5. The selling price of the prescription shall be the cost of the ingredients and container plus 50 percent plus the appropriate fee provided in the time-cost schedule (see Item 7).

(Continued)

CALIFORNIA-SDSW-MANUAL-MC

Rev. 407 replaces Rev. 293

Effective 7/1/61

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CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

MC-046

SCHEDULE OF MAXIMUM ALLOWANCES

Regulations

MC-046

(Continued)

MC-046

6. All compounded prescriptions shall be priced according to this schedule with no exception.

7. Time-Cost Schedule

CAPSULES AND PAPERS

6	\$1.30	30	\$2.50
12	1.45	36	2.80
15	1.70	40	3.00
18	1.85	50	3.55
20	1.95	60	4.10
24	2.10	100	5.60

OINTMENTS

min.	\$1.35	4 oz.	\$2.10
2 oz.	1.75	6 oz.	2.40
3 oz.	1.90	8 oz.	2.70
		16 oz.	\$3.85

SUPPOSITORIES

min.	\$2.10	36	\$3.70
18	2.50	50	4.80
24	2.90	100	8.25

NOSE AND EAR DROPS-SPRAYS

1/2 oz.	\$1.15	2 oz.	\$1.30
1 oz.	1.20	4 oz.	1.35

COLLYRIA

min.	\$1.30	3 oz.	\$1.30
		4 oz.	\$1.50

EMULSIONS

min.	\$1.35	12 oz.	\$2.25
6 oz.	1.70	16 oz.	2.40
8 oz.	1.80	32 oz.	2.70

POWDER-BULK BY VOLUME

2 oz.	\$1.15	8 oz.	\$1.70
4 oz.	1.35	12 oz.	2.10
6 oz.	1.55	16 oz.	2.55
		32 oz.	\$4.10

INTERNAL-EXTERNAL (Liquid)

min.	\$1.00	8 oz.	\$1.30
4 oz.	1.15	12 oz.	1.35
6 oz.	1.20	16 oz.	1.75
		32 oz.	\$2.10

C. Minimum Charge and Adjustment to Nearer Five Cents

A minimum charge of \$1.20 may be made provided this does not exceed the usual retail price.

Total charges are rounded to the nearer five cents.

D. Definition of Wholesale Cost

The wholesale cost is the cost to the druggist or the cost listed in American Druggist Blue Book (American Druggist) or Drug Topics Red Book (Topics Publishing, Inc.) whichever is less.

2. Drugs which may be dispensed by the druggist under federal or state laws without a prescription:

- Fair trade items - the maximum payment to be made is the fair trade price.
- Items not classified as fair trade - The wholesale cost may be increased by an amount not to exceed 50 percent.

3. Medical Supplies:

- Fair trade items - The maximum payment to be made is the fair trade price.
- Items not classified as fair trade - The maximum is regular retail price less 10 percent.

CALIFORNIA-SDSW-MANUAL-MC Issue Rev. 294 replaces 04-36 and 140 Effective 3/1/61

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CONTINUATION SHEET
 R FILING ADMINISTRATIVE REGULAT
 WITH THE SECRETARY OF STATE
 (Pursuant to Government Code Section 11380.1)

MC-047 NURSING SERVICES

MC-047

1. a. Visit by nurse from Visiting Nurse Association or Public Agency at actual cost

The allowance not to exceed
 (Visit cost will be determined by the Method I
 Cost Analysis of the National League for Nursing.)

\$6.00

- b. Visit by physical therapist from Visiting Nurse Association or Public Agency

1½ times nurses visit
 cost - not to exceed
 fees set by schedule
 of maximum allowances
 (MC-048).

2. Visit by private nurse

\$6.00

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These Regulations are designated to become effective July 1, 1961.

CONTINUATION SHEET
R FILING ADMINISTRATIVE REGULA
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

5

May 29, 1961

DEPARTMENT BULLETIN NO. 608 (Fiscal)

TO: COUNTY WELFARE DEPARTMENTS
COUNTY AUDITORS
CALIFORNIA PHYSICIANS' SERVICE

Subject: Medical Care Prescriptions

Effective July 1, 1961 each county shall submit to the SDSW:

1. A copy of each prescription, Form MC 165, completed in accordance with current instructions, or
2. A punch card containing the same information from those counties which routinely process prescriptions on EAM or EDP equipment. This information will be furnished by California Physicians' Service for those for which it acts as fiscal agent.

Counties which use punch card equipment for welfare accounting or statistics but do not routinely punch cards for prescriptions, may submit either punch cards or a copy of each paid prescription.

Punch cards or prescription copies shall be submitted to the SDSW by the 15th of each month, for those prescriptions processed for payment during the previous month.

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These Regulations are designated to become effective July 1, 1961.

CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

The following regulations are repealed effective July 1, 1961:

MC-031.2 Drugs for Old Age Security and Aid to the Blind Paid by
Medical Care Trust Fund-Unrestricted by Diagnosis

MC-031.3 Drugs Paid for Old Age Security and Aid to the Blind by
Medical Care Trust Fund-Restricted by Specific Diagnosis

Department Bulletin No. 600 (MC) Drug Formulary

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FACE SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

RECEIVED FOR FILING

JUN 28 1961

Division of Administrative Procedure

ENDORSED

APPROVED FOR FILING
(Gov. Code 11380.1)

JUN 28 1961

Division of Administrative Procedure

Copy below is hereby certified to be a true and correct copy of regulations adopted, or amended, or an order of repeal by:

State Department of Social Welfare

(Agency)

Dated: June 27, 1961

By: J. M. Nedemeyer

Director

(Title)

FILED

In the office of the Secretary of State
of the State of California

JUN 28 1961

At 3:00 o'clock PM.

FRANK M. JORDAN, Secretary of State

By: [Signature] Assistant Secretary of State

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AI-110 RECEPTION AND CARE OF AGED PERSONS

AI-110

Persons, corporations, or associations are subject to license as a home for the aged if they solicit and/or receive aged persons into a physical setting with the intention or practice of assuming for them responsibilities which go beyond that customarily associated with a landlord-tenant relationship. In determining the need for a license, the intention, obligations, or practices which shall be construed as indications or evidence of a need for a license, include the following:

1. Identification of the establishment and the service offered by any name, description or advertisement which implies a service to aged people other than that of housing, a place serving food to the public, a nursing or convalescent home, or a psychiatric care facility.
2. Implied or actual assumption of responsibility for general oversight and, as needed, personal care to aged persons, such as help with bathing, dressing, eating, care of clothing, mending, laundry, personal shopping, transportation, health supervision, assistance in maintaining social and recreational contacts, etc.

Any practice, intention or obligation which does not include all the services required in regulations governing the licensing of reception and care of the aged shall not, however, be presumed to excuse any person, corporation, or association from the need for a license.

AI-153.10 NEW BUILDINGS

AI-153.10

As used in this chapter, "new buildings" mean (1) a building or buildings constructed after January 15, 1956, and (2) a building or buildings not approved for use by a licensed institution for aged persons prior to that date.

New buildings shall meet all of the rules and regulations of the State Department of Social Welfare.

These Regulations are designated to become effective August 1, 1961

AI-153.15 EXISTING BUILDINGS

AI-153.15

As used in this chapter, "existing buildings" mean a building or buildings in continued use by a licensed institution for aged persons prior to and after January 15, 1956.

Correction of deviations from regulations shall not be required for existing buildings which were determined to be in substantial conformity with this chapter on January 15, 1959, if there is no substantial change in the conditions which warranted the finding.

DO NOT WRITE IN THIS SPACE

These Regulations are designated to become effective August 1, 1961

CONTINUATION SHEET
OR FILING ADMINISTRATIVE REGULATION WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Manual Section AI-153.13 New Occupancies of Existing Buildings is to be repealed effective August 1, 1961.

The following Department Bulletins are to be repealed effective July 1, 1961:

597 (MC) Annual Health Evaluation for OAS Recipients, Effective April 1, 1961

597A(MC) Annual Health Evaluation for OAS Recipients

The following Department Bulletins are to be repealed effective August 1, 1961:

572 (Stat) Weekly Wire Report on General Home Relief and Aid to Needy Children During Winter Months

585 (Stat) Transfer Rate Sample Study County Medical Care Revolving Funds

604 (Stat) Report on Concurrent Receipt of Public Assistance and Old Age, Survivor's and Disability Insurance in February 1961

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CONTINUATION SHEET
**FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE**
(Pursuant to Government Code Section 11380.1)

F-924

STATE SUBVENTION

Fiscal

F-924

ALLOCATION OF SPECIAL DEPOSIT TRUST FUND FOR MATERNITY CARE

F-924

Funds for maternity care will be allocated only to counties maintaining a licensed county adoption agency. Funds will not be advanced to counties. Distribution of monies in the Special Deposit Fund will be made only through reimbursement of claims.

A. METHOD OF ALLOCATION

The State Department of Social Welfare will estimate the amount of funds to be available and the amount to be allocated to each county. The allocation will be based upon children accepted, funds available, maternity care provided and average costs.

B. NOTIFICATION OF ALLOCATION

The State Department of Social Welfare will notify each county maintaining a licensed adoption agency, before the start of each fiscal year, of the amount which will be made available for payment of costs of maternity care. This amount will constitute the maximum which will be reimbursed by the State unless approval is granted by the State to exceed the annual allocation.

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CALIFORNIA-SDSW-MANUAL- FISCAL

Rev. 637 replaces Rev. 517 Effective 8/1/61

CONTINUATION SHEET
OR FILING ADMINISTRATIVE REGULA NS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

FINDING OF EMERGENCY

The following regulations, amendments to regulations, and repeals of regulations are emergency measures necessary to the immediate preservation of the public health, safety and general welfare within the meaning of the provisions of Section 11421(b) of the Government Code:

1. Repeal of Regulation MC-031.6, Section II C pertaining to OAS Health Evaluations, effective July 1, 1961.
2. Repeal of Bulletins 597 and 597A - Annual Health Evaluation

The following facts constitute the emergency:

1. There was introduced on March 6, 1961, in the Senate of the State of California Senate Concurrent Resolution No. 35 whereby it was proposed that the Legislature resolve to request the State Department of Social Welfare and the State Social Welfare Board to revoke their authorization for complete annual physical examinations for Old Age Assistance recipients and to refrain from reinstating such authorization until such time as the Legislature has investigated the matter and signified its approval of such authorization.
2. This Resolution passed the Senate on March 20, 1961 and the Assembly on June 12, 1961.

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CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Regulations

SCOPE AND LIMITATIONS

MC-031.6

MC-031.6 SERVICES AVAILABLE WITH
PRIOR AUTHORIZATION

MC-031.6

I. Services for which prior authorization may be waived (MC-053.50)

- A. Home and/or office visits from or to practitioners (other than dentists and podiatrists) in excess of three such visits for any other illness or beyond the 90th day from the first visit.
- B. Any service rendered by podiatrists.
- C. (Deleted 7/1/61)
- D. Elective laboratory services other than urinalysis and blood counts.
- E. Elective radiological and outpatient radiotherapy services.
- F. Services of private nurses, visiting nurse associations, or nurses in public agencies rendering home nursing in excess of five visits for any one illness.
- G. Dental care for children under 13 years of age as necessary to prevent tooth loss and maintain dental health. During the period beginning July 1, 1961, and ending December 31, 1961, such care may also be given to children aged 13 through 17 years.
- H. Complete histories and physical examinations by physicians.
- I. Services of physical therapists as prescribed by physicians.
- J. For OAS recipients all essential dental care necessary to restore and maintain adequate dental health pursuant to standards established by the Director of the SDSW.
- K. Elective office surgery.

II. Services for which prior authorization may not be waived.

- A. Services of rehabilitation facilities meeting the standards of the Vocational Rehabilitation Service.
- B. For Old Age Security recipients only, eye appliances listed in the Schedule of Maximum Allowances. (MC-045.1)
- D. For OAS and ATD recipients only, care, services, supplies, and equipment determined by a certified rehabilitation facility as necessary during the period the rehabilitation plan is in effect. (See MC-018)

CALIFORNIA-SDSW-MANUAL-MC

Rev. 1187 replaces Rev. 397

Effective 7/1/61

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CONTINUATION SHEET
OR FILING ADMINISTRATIVE REGULA 45
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

FINDING OF EMERGENCY

The following bulletin is an emergency measure necessary to the immediate preservation of the public health, safety and general welfare within the meaning of the provisions of Sec. 11421(b) of the Government Code:

Bulletin No. 609 (OAS, AB, ANC, ATD, MC) Subject: Manual
Section MC-040.1, Procedure #029.

The following fact constitutes the emergency:

Failure to adopt this Bulletin with an immediate effective date may have an adverse effect upon the fiscal resources appropriated for health programs administered by other state agencies. The resulting necessity for these other state agencies to curtail their services to ill and needy people entitled to medical and remedial care would be contrary to the public health, safety and welfare.

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CONTINUATION SHEET
FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

W&IC 4555

EDMUND G. BROWN, GOVERNOR

STATE OF CALIFORNIA

DEPARTMENT OF SOCIAL WELFARE

J. M. WEDEMEYER, DIRECTOR

722 CAPITOL AVENUE, SACRAMENTO 14

June 26, 1961

DEPARTMENT BULLETIN NO. 609 (OAS, AB, ANC, ATD, MC)

TO: COUNTY WELFARE DEPARTMENTS
COUNTY AUDITORS
CALIFORNIA PHYSICIANS' SERVICE

Subject: Manual Section MC-040.1
Procedure #029

On May 25, 1961, the Social Welfare Board adopted an amendment to Section MC-040.1, restoring procedure #029 (office visit of greater than routine nature, etc.) with an allowance of \$6 to the Schedule of Maximum Allowances for physicians.

The Department of Finance has expressed grave concern over the effect of this action on the closed-end appropriations of the State Department of Public Health and other departments which purchase similar medical services. Moreover the Budget Act of 1961 as passed by the Legislature contains the following provision with respect to the appropriation made to the Department of Social Welfare (Item #257):

"...any rule or regulation adopted by the State Social Welfare Board during the fiscal year 1961-62 which adds to the cost of any public assistance program shall only be effective from and after the date upon which it is approved by the Director of Finance."

Since the restoration of item #029 will add to the cost of the public assistance programs in 1961-62 and in view of the concern expressed by the Department of Finance the effective date of the aforementioned action taken on May 25, 1961, is hereby deferred from July 1, 1961, and until further notice.

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These Regulations are designated to become effective JUL 1, 1961

FACE SHEET
**FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE**
(Pursuant to Government Code Section 11380.1)

RECEIVED FOR FILING

JUL 28 1961

Division of Administrative Procedure

ENDORSEDAPPROVED FOR FILING
(GOV. CODE 11380.2)

JUL 28 1961

Division of Administrative Procedure

DO NOT WRITE IN THIS SPACE

Copy below is hereby certified to be a true and correct copy of regulations adopted, or amended, or an order of repeal by:

State Department of Social Welfare

(Agency)

Dated: July 26, 1961

By: *J. M. Hedemeyer*

Director

(Title)

FILEDIn the office of the Secretary of State
of the State of California

JUL 28 1961

At 10:45 o'clock

9 M.

FRANK M. JORDAN, Secretary of State

By: *Walter L. Butler*

Assistant Secretary of State

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F-840 EXPENDITURES CHARGEABLE TO THE CATEGORICAL AID GROUP

F-840

Expenditures for purposes of administration chargeable to categorical aid programs must be directly pertinent or reasonably related to those programs and must not be properly chargeable to other programs.

Among the activities involving administrative costs for which federal participation may be claimed are:

1. Supervising the operation of the categorical aid programs;
2. Developing, evaluating, and modifying standards of operation;
3. Maintaining social, financial, and statistical records;
4. Preparing and presenting information to official bodies and the public;
5. Determining the original and continued eligibility of individuals for financial aid, ascertaining the amount of aid to be granted, and providing the aid payments;
6. Rendering personal services to applicants or recipients to assure maximum benefit from the money payment in relation to personal, family, and community resources;
7. Costs of services with respect to:

(Section Continued on Next Page)

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CONTINUATION SHEET
F-840 FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

F-840

ADMINISTRATIVE EXPENDITURES

Fiscal

F-840 (Continued)

F-840

- a. Providing information, making analyses, investigating, counseling, consulting, planning, and referral, including the cost of transportation and other expenses necessary to enable the applicant or recipient to receive services in respect to legal, medical, and social problems, excluding the cost of legal, medical, educational, rehabilitative, and remedial services that go beyond consultation, diagnosis, and planning;
- b. Mental and physical examinations and other diagnostic services necessary to determine the mental or physical condition of the applicant or recipient or of a member of the household affecting his health and well-being, including expenses necessary to secure the service, but excluding the costs of medical treatment;
- c. Services, including consultation and arrangements for counsel, necessary in the adjustment of legal problems of the applicant or recipient including the official fees, the costs of documents and other expenses necessary to secure the service, but excluding attorney's fees and, except as provided in d, the costs of judicial proceedings;
- d. Guardianship proceedings for applicants or recipients of public assistance;
- e. General and incidental community activities required by virtue of the position or office held, and, under conditions specified in the Public Assistance Manuals, community planning activities involving assignment of staff time or loan of staff;
- f. Organized special resources within the public welfare agency for activities specified in the Public Assistance Manuals as organized special resources, to the extent that they serve public assistance applicants and recipients; (these include such items as homemaker services; foster home finding program for the aged; volunteer service; social rehabilitation, including specialized employment placement and vocational training for persons with multiple social handicaps; and services to promote self-care objectives for the aged and handicapped). For requirements of homemaker plans see Fiscal Manual Section F-845.
- g. Proceedings in recovery of amounts due from or repayable by or on behalf of recipients (or former recipients) of aid.
- h. Planning for continuity of public welfare programs in the event of enemy attack or other disaster (see Sec. F-882, Civil Defense).

(W&IC 1553, 2186, 3087, FSSA)

CONTINUATION SHEET
**F FILING ADMINISTRATIVE REGULATORY
 WITH THE SECRETARY OF STATE**
 (Pursuant to Government Code Section 11380.1)

F-881

ADMINISTRATIVE EXPENDITURES

Fiscal

F-882

CIVIL DEFENSE

F-882

1. Reimbursable Costs

Financial participation is available for Public Welfare Departments' costs in planning and preparing for the continued operation of welfare programs in case of enemy attack or natural disaster. Reimbursement is provided to promote advance preparation by Welfare Departments so services to welfare recipients will not be seriously hindered.

Reimbursement will be available in the following costs:

- a. Training programs for welfare personnel to continue operation.
- b. Developing and publishing procedures to guarantee continued operation.

Reimbursement is also available for the cost of participating in planning for the division of responsibilities among agencies and identifying the responsibilities of the welfare department to affect a good community plan.

2. Nonreimbursable Costs

Reimbursement is not available for:

- a. Costs incurred during a disaster.
- b. Any costs related to relocation of personnel.

(W&IC 1553, 2186, 3087, FSSA)

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CONTINUATION SHEET
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FINDING OF EMERGENCY

The following regulations, an addition to the Manual of Policies and Procedures, Aid to Needy Children, and revision of Fiscal Manual Secs. F-525, A and C, and F-730, A, are emergency measures necessary to the immediate preservation of the public health, safety and general welfare within the meaning of the provisions of Section 11421 (b) of the Government Code:

- | | |
|--|---|
| 1. Aid to Needy Children
Manual Section C-319 | Services to Children and Their Parents
and Foster Parents When a Child Has
Been Removed from His Home by Court
Determination |
| 2. Fiscal Manual Section F-525(A and C) | Requirements for Federal
Participation - ANC |
| 3. Fiscal Manual Section F-730(A) | Claiming of Aid Payments |

The following facts constitute the emergency:

The services provided for in the regulation are urgently needed, so that continuing care and protection is provided for children subject to placement following court determination; for the parents of the said children so that conditions in the home may be improved as soon as possible so that the children may return there; and to assist the foster parents in the clarification of the relationship involved in the placement.

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F-525

GOVERNMENTAL PARTICIPATION

Fiscal

F-525

REQUIREMENTS FOR FEDERAL PARTICIPATION - ANC

F-525

Federal participation in ANC is available for cases in which the following requirements are met:

1. The child is living in a foster home as a result of a judicial action meeting the conditions specified in Section C-319 of the Aid to Needy Children Manual.
2. The child is living in the home of a relative and the payee is one of the following:
 - a. The relative in whose home the child is living
 - b. The legal guardian of the relative with whom the child is living
 - c. In an emergency, a person acting temporarily for the relative with whom the child is, or was, living.

In addition, federal participation is available in the payment of assistance for any one of the needy relatives specified in Item 2a above, with whom the federally eligible child is living, providing the following requirements are met:

1. The relative with whom the child is living is exercising primary responsibility for the care and control of the child.
2. The relative is not receiving any other form of categorical assistance.
3. A money payment is made for the child for the month in which federal participation is claimed for the relative.

(FSS Admin.)

(Continued)

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
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Fiscal GOVERNMENTAL PARTICIPATION F-525

F-525 (Continued) F-525

A. DEFINITION OF LIVING IN THE HOME OF A RELATIVE FOR FEDERAL PARTICIPATION

For purposes of federal participation in the payment of ANC, the child specified in Sec. F-525, Item 2, must be living with a person included in one of the following groups:

1. Any blood relative, including those of half-blood, except second or third cousins. Relationship to persons of preceding generations as denoted by prefixes of grand, great, or great-great are within this definition.
2. Stepfather, stepmother, stepbrother, and stepsister.
3. Any person who legally adopted the child or adopted the child's parent; also the natural children or other adopted children of such person.
4. Spouses of any persons named in the above groups. Such relatives may be considered within the scope of this provision even though the marriage is terminated by death or divorce.

A child shall be considered to be living in the home of a relative as long as the relative takes responsibility for the care and supervision of the child, even though circumstances may require temporary absence of either the child or the relative from the home. Temporary absence which does not affect the relationship of the child to the relative under this definition includes but is not limited to:

1. Hospitalization of the child or relative, if the illness is of such a nature that a return to the family can be expected and the relative's responsibility for the care and supervision of the child continues during the hospitalization. (ANC may not continue more than two calendar months for a child in a public hospital. See Sec. C-141 of the Manual of Policies and Procedures - ANC.)
2. Attendance at school, if the purpose is primarily for obtaining an education or vocational training and the relative retains responsibility for the child.
3. Visiting, vacationing, moving to other communities, and similar situations.

A child shall be considered to be living in the home of a relative if that relative has a plan to establish a home for the child. Assistance may be granted prior to the child's arrival in the home, as a resource to assist in accomplishing the plan. The child shall be considered to be living in the home only if he goes to live with that relative within thirty days of the receipt by the relative of the first payment. Federal participation is available for such initial payment. (W&IC 1560, FSS-Admin.)

(Continued)

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Fiscal

GOVERNMENTAL PARTICIPATION

F-525

F-525 (Continued)

F-525

C. DEFINITION OF ELIGIBLE PAYEE FOR FEDERAL PARTICIPATION

To obtain federal participation in ANC the payee must be either:

1. A boarding-home mother as provided in F-525, Item 1;
Or,
2. One of the following:
 - a. The relative with whom the child is living provided he is within the relationship listed in Item A.
 - b. The guardian, if there be one, of the relative with whom the child is living.
 - c. The person acting for the relative during a temporary emergency period. If an emergency deprives the child of care by the relative with whom he has been living, payments may be made for a temporary period to a person acting for the relative. Such emergency would include one in which there was not sufficient time to determine whether there is another relative in whose home the child could live or to effect plans for the child's continuing care and support in the home of another relative. Such emergencies may arise in cases of the relative's sudden death, desertion, imprisonment, or commitment to a hospital for the mentally ill, etc. The period that payments are made to an emergency payee shall be limited to the time actually necessary to make and carry out plans for the child's continuing care and support in the home of another relative.

(W&IC 1560)

(Section Continued on Next Page)

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F-730

AID CLAIMS

Fiscal

F-730 CLAIMING OF AID PAYMENTS

F-730

A. CLAIMS-GENERAL

County payments of categorical aid shall be listed in state case number order on aid payrolls, Forms ABD 801, ABD 801-V, CA 801 and CA 801-BHI. Exceptions: Nonfederal (X) cases may be reported on separate pages of the payroll. BHI cases may be listed alphabetically by payee. OAS, ANB and ATD, VPMI claims may also be arranged in alphabetical order by names of institutions. If the alphabetical arrangements are used and there is more than one case with the same payee or in the same institution, they shall be listed in state case number order under the name of each payee or institution.

The payments being claimed shall be listed in separate payroll sections according to whether they are included in the continuing roll, current supplemental rolls, or rolls for payments applicable to prior months.

On all payrolls and contra rolls, the following information shall be provided in the appropriate headings and columns:

1. The name of the county filing the claim.
2. The month and the year of the claim.
3. The type of roll, i.e., payroll, cancellation contra roll, or repayment contra roll.
4. State case numbers.
5. In OAS, ANB, APSB, and ATD payrolls and contra rolls the payee's name exactly as it appears in the signature on the application. If county mechanical equipment makes it advisable, the given initials only need be shown. If a guardian of the estate has been appointed, both the name of the guardian and the name of the recipient shall appear on the aid payroll. In OAS, ANB, and ATD, VPMI claims also include the name of the institution.

In ANC (both family group rolls and boarding home rolls) the name of the payee shall be shown exactly as it appears on the latest authorization document.

The following will govern the reporting of names of the children on the claims:

a. In ANC family group claims

1. The names of the children in a home of an eligible relative need not be shown.
2. The name and the amount of payment for each child living in a family boarding home as a result of judicial actions as specified in ANC Manual Section C-319 and Fiscal Manual Section F-525 Item 1 will be shown separately. The name of the payee will also be shown.

b. In ANC boarding home and institutions claims the name and the amount of payment for each child will be shown separately. The name of the payee will also be shown.

(Continued)

CONTINUATION SHEET
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Fiscal _____ AID CLAIMS _____ F-730

F-730 (Continued) _____ F-730

6. In OAS, ANB, and ATD the warrant amount and the persons count. In APSE, the warrant amount.

In OAS, ANB and ATD, VPML, the persons count for each case on which no direct payment is made to the recipient is entered in the persons count column (3) in the "Payment to Institutions" section. If there is a direct payment to the recipient, the persons count is posted in the column (5) in the "Payment to Recipients" section, and no count is shown in Col. 3. The amount paid to the institution for each recipient, the amount paid to each recipient, and the total payment to both. If the payroll is arranged alphabetically by the names of institutions the total amount paid to each institution shall be shown in the remarks column opposite the name of the institution. If the payroll is arranged in state case number order the total amount paid to each institution shall be shown at the end of the payroll.

In ANC, the persons count in each case for individuals eligible and ineligible for federal participation segregated as to needy eligible relative, eligible children and ineligible children; the warrant amount including any county supplemental aid; and the amount in excess of state basis (county supplemental aid).

In ANC (family group claim) for those children living in a foster home as a result of a judicial action, show the persons count in each case for children eligible and ineligible for federal participation, the amount of aid paid for each child including any county supplemental aid, and the amount in excess of the state basis (county supplemental).

The maximum for state participation for children included in the family group payroll living in a foster home as a result of judicial actions is \$75. Any amount paid for any individual child under this provision in excess of \$75 is county supplemental aid.

In ANC-BHI, the number of children, the warrant amount including any county supplemental aid, and the amount in excess of state basis (county supplemental aid). For periods prior to October 1, 1957, the state basis amount shall be segregated into columns according to county residence. In ANC-BHI, the amounts paid and county supplemental aid shall not be shown in total for each case but shall be segregated individually for each child in the case.

(Continued)

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F-730	AID CLAIMS	Fiscal
F-730 (Continued)		F-730

7. The warrant numbers and dates. If all warrant numbers on a given roll or page carry the same date, the date may be indicated at the beginning of the roll or top of the page rather than individually for each warrant.

In OAS, ANB and ATD, VPMI claims, journal entry identifications may be used instead of warrant numbers for payments to the institutions.

8. All pages in a payroll or contra roll section shall be numbered consecutively and shall carry individual totals by page for each column. In addition to the column totals, the numbers of persons by participation status shall be totaled at the foot of each page. Page totals shall be added and footed on the last page of each section.

(Continued)

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F-730 (Continued)		F-730

9. On zero grant listings show name, state number, total aid paid and status (i.e., Regular on Non-Federal). For claiming purposes zero grants are for those cases for which the grant was reduced to zero to adjust for overpayments for prior months within the current adjustment period (see F-1020 C).
10. Incapacitated parents list for ANC family cases will show state number and name of the incapacitated parent. The list will not include incapacitated parents included in the payroll as needy relatives since this would duplicate the persons count (see F-1020 C).
11. In order to be reimbursed for the state share of the transfer to the MC Revolving Fund of OAS, ANB and APSB assistance funds, these transfers must be included as expenditures against the assistance funds. This will be accomplished by posting to Line 8, Columns A, D and J the amount of the transfer. The amount to be transferred will be determined by multiplying the number of recipients shown on the claim for the previous month (Column D, Line 5 plus Line 6) times the average special need factor.

This average special need factor will be redetermined semi-annually. At the semi-annual redetermination counties will adjust for any differences in persons counts caused by SDSW office audit of the claims.

On the Medical Care Certification, Form MC 800, the amount of transfer is also posted to Line 7. If, after the first month, the total medical care is less than the amount transferred for any program, the unexpended amount of the assistance fund transfer shown on Line 8 must be added to the amount transferred to the next month and the total will be shown on Line 7 of the Medical Care Claim Certification Form MC 800.

(Continued)

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F-730

AID CLAIMS

Fiscal

F-730 (Continued)

F-730

12. In the ANC family group claim, provision is now made to include payments for a child living in a foster home as a result of judicial action meeting the conditions specified in ANC Manual Section C-319. The state maximum for these payments is \$75 per child. The amount paid for each child must be shown separately and the amount in excess of state basis (county supplemental aid) shall be shown separately for each child. Federal participation is available for these children (see Fiscal Manual Section F-525). Payment to the boarding-home mother as payee for these children is made at the end of the month. These payments made at the end of the month to the foster family for these children will be kept on a separate page(s) as part of the current month's supplemental payroll.

(Continued)

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Regulations AID PAYMENTS A-227.60

A-227.60 ADJUSTMENT OF UNDERPAYMENT BY AUTHORIZATION OF RETROACTIVE AID A-227.60

Definition

Retroactive aid is aid authorized in a subsequent month for some preceding month or months.

ADJUSTMENT BY COUNTY ADMINISTRATIVE ACTION

Underpayment is adjusted by administrative action authorizing payment of retroactive aid under the circumstances prescribed below and within the time limits specified.

1. Underpayment resulting from an administrative error or inadvertence (see Sec. A-227.51).

Such underpayment (including underpayment resulting from a denial or discontinuance due to administrative error or inadvertence) is to be adjusted as provided in W&IC Sec. 103.3, Item f.

2. Underpayment resulting from other causes.

Underpayment resulting from causes other than "administrative error or inadvertence" is to be adjusted in accord with whichever of the following circumstances is appropriate:

- a. Recipient Eligible to a Larger Grant than that Authorized

When aid is paid in the amount authorized but it is later determined that the recipient was eligible for a greater amount (as determined in accord with Sec. A-221), the underpayment is to be adjusted, provided the additional amount due can be authorized before the end of the fourteenth month following the month for which the recipient was underpaid.

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 (Pursuant to Government Code Section 11380.1)

A-227.60

AID PAYMENTS

Regulations

A-227.60 (Continued)

A-227.60

b. Aid Denied or Discontinued to an Eligible Person

When, within 12 months after date of applicant's or recipient's notification of a denial or discontinuance, the county obtains additional information which indicates eligibility existed for the denied or discontinued payments, or discovers the denial was improper when taken as it was apparent the applicant would be eligible within 90 days (see Sec. A-014.45), the underpayment is to be adjusted provided:

- (1) The applicant or recipient met his responsibility for reporting promptly all facts required of him pursuant to W&IC Sec. 103.3, Item b; and
- (2) The retroactive aid can be authorized before the end of the fourteenth month following that in which the discontinuance or denial action occurred.

(The authorization is to be in the amount to which the person was eligible and for the period during which he would have received aid if such aid had been granted or continued instead of denied or discontinued.)

c. Incorrect Beginning Date

When aid is not authorized in accord with the code and regulations governing the beginning date and underpayment occurs on a new case, a restoration, an inter-county transfer, or a transfer between OAS, and ANB, such underpayment is to be adjusted provided the amount due can be authorized before the end of the fourteenth month following the month in which aid is to have begun.

ADJUSTMENT BY THE APPEAL PROCESS

Underpayment (regardless of cause) shall be adjusted by authorization of aid in the amount and for the period ordered by the SSWB or agreed to by the SDSW (see Secs. 055.3 and 055.4).

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B-016

DETERMINATION OF ELIGIBILITY

Regulations

B-016.13 RECIPIENT MOVES TO ANOTHER COUNTY TO "MAKE HIS HOME" - ANB-APSB

B-016.13

A recipient is considered "to make his home" in the county in which he is physically present. "If a recipient moves from one county to another pursuant to W&IC Sections 3090 and 3450, he is considered 'to make his home' in the county to which he has so moved and inter-county transfer arrangements are initiated immediately. (See B-010.20, County Responsibility for Applications, Reapplications, and Restorations for Exceptions.)"

Exceptions:

1. If the recipient is maintaining a living place in some other county than that in which he is physically present and plans to return to that living place within four months, it is considered that he "makes his home" in the county in which such living place is maintained. (The four months start to run from the date the county paying aid determines that the recipient is "maintaining a home" in some county other than that in which he is physically present. If he fails to return to that home within the four-month period, he is considered to have removed to the county in which he is physically present "to make his home.")
2. If the county in which the recipient "makes his home" does not have adequate facilities to care for the recipient and as a result places him in a nursing home or hospital in another county, the county in which the recipient "makes his home" remains unchanged by such placement for as long as circumstances beyond his control require that he remain in another county.
3. The county in which a recipient "makes his home" is not changed during any absence from the state provided residence outside the state is not established.
4. A regular student at the California School for the Blind, the Oakland Orientation Center for the Blind, a college, university or other school, including a trainee who is enrolled in a short period of training who is a recipient of aid to the blind through a county other than that in which the school is located is considered "to live" in the county paying the aid at the time of enrollment in the school or training plan, provided it is the recipient's plan to return to that county upon completion of the school term, or training. If the recipient fails to return to the county paying aid, after completion of the training period, he is considered to have removed to the county in which he is physically present "to make his home."
5. If the blind person is a minor, see Sec. B-010.20, Item A, 2, d.

CALIFORNIA-SDSW-MANUAL- AB

Rev. 1190 replaces Rev. 456

Effective 9/1/61

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Regulations

RECORDS, FORMS AND CONTROLS

B-024

B-024 REQUIRED FORMS - ANB-APSB

B-024

The following forms, completed in accord with instructions for their use are required when the circumstances to which they relate exist:

BL 200	Application for Aid to the Blind (see Sec. B-011.11)
BL 225	Statement of Responsible Relative Under Aid to the Blind Laws (see Sec. B-153.3)
BL 227	Physician's Report of Eye Examination (see Sec. B-192.01)
BL 227 (Supplement)	Report of Observation of Visual Fields
BL 227A	Optometrist's Report of Eye Examination (see Sec. B-192.01)
ABCD 215	Notification of Transfer (see Handbook Sec. B-024.56)
ABD 235	Certification from State Department of Mental Hygiene of Applicant's Release from State Hospital (see Sec. B-013)
DPA 1	Request for Federal OASI and Nonmedical Disability Information (see Sec. B-213)
DPA 6	State Department of Social Welfare Appeal as to Responsibility for Support (see Sec. B-017)

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Rev. 1191 replaces Rev. 1084

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B-192.03

DETERMINATION OF BLINDNESS

Regulations

B-192.03 REVIEW OF EXAMINATION REPORTS BY THE SDSW - ANB-APSB

B-192.03

All reports of eye examinations and of neuropsychiatric or neurological examinations shall be reviewed and acted upon by the SDSW. Appropriate action by the county is taken in accord with the certification of the SDSW as to blindness. (See B-011.20, Items 8 and 9.) An examiner will be required to complete an additional form Bl 227 (supplement) to determine eligibility if there is a question of the results of the visual fields only, as in glaucoma, hysterical amblyopia and other conditions.

B-198

EXPENSES IN CONNECTION WITH EYE OR NEUROPSYCHIATRIC
OR NEUROLOGICAL EXAMINATIONS - ANB-APSB

B-198

There is to be no expense to the applicant, recipient or appellant for any eye and/or neuropsychiatric or neurological examination required by the SDSW.

The following allowances constitute the maximum payment which is considered proper county administrative expense for the specified service

Eye examination including refraction, tonometry, mydriatic or cycloplegic when necessary, peripheral fields, with report by an eye physician	\$16.00
Eye examination including refraction and report by an eye physician to resolve a conflict in eye examination reports of previous examiners	20.00
Observation of visual fields only (on special request by the SDSW)	8.00
Eye examination including refraction and peripheral fields with report by an optometrist	15.00
Complete neuropsychiatric or neurological examination and report	28.00

Necessary transportation expense to secure required eye and/or neuropsychiatric or neurological examinations is allowable administrative expense. (See Appendix Fiscal Manual Sections, Sec. F-875)

CALIFORNIA-SDSW-MANUAL-AB

Rev. 1199 replaces Rev. 1178

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Regulations AID PAYMENTS B-227.60
B-227.60 ADJUSTMENT OF UNDERPAYMENT BY AUTHORIZATION OF RETROACTIVE AID - B-227.60
ANB-APSB

Definition

Retroactive aid is aid authorized in a subsequent month for some preceding month or months.

ADJUSTMENT BY COUNTY ADMINISTRATIVE ACTION

Underpayment is adjusted by administrative action authorizing payment of retroactive aid under the circumstances prescribed below and within the time limits specified.

- 1. Underpayment resulting from an administrative error or inadvertence (see Sec. B-227.51).

Such underpayment (including underpayment resulting from a denial or discontinuance due to administrative error or inadvertence) is to be adjusted as provided in W&IC Sec. 103.3, Item f.

- 2. Underpayment resulting from other causes.

Underpayment resulting from causes other than "administrative error or inadvertence" is to be adjusted in accord with whichever of the following circumstances is appropriate:

- a. Recipient Eligible to a Larger Grant than that Authorized

If aid is paid in the amount authorized but it is later determined that the recipient was eligible for a greater amount (as determined in accord with Sec. B-221), the underpayment is to be adjusted, provided the additional amount due can be authorized before the end of the fourteenth month following the month for which the recipient was underpaid.

Underpayment of \$2.00 or less for a particular month is adjusted only when a necessary increase of \$2.00 or less in the continuing grant (see Sec. B-226, Changes in Amount of Payment) was not made effective until after the second month following that in which the changed circumstances were reported. Payment of retroactive aid in such circumstances shall begin with such second month.

(Continued)

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B-227.60

AID PAYMENTS

Regulations

B-227.60 (Continued)

B-227.60

b. Aid Denied or Discontinued to an Eligible Person

If within 12 months after date of applicant's or recipient's notification of a proper denial or discontinuance, the county obtains additional information which indicates eligibility existed for the denied or discontinued payments, or discovers the denial was improper when taken as it was apparent the applicant would be eligible within 90 days (see Sec. B-014.45) the underpayment is to be adjusted provided:

- (1) The applicant or recipient met his responsibility for reporting promptly all facts required of him pursuant to W&IC Section 103.3, Item b; and
- (2) The retroactive aid can be authorized before the end of the fourteenth month following that in which the discontinuance or denial action occurred.

(The authorization is to be in the amount to which the person was eligible and for the period during which he would have received aid if such aid had been granted or continued instead of denied or discontinued)

c. Incorrect Beginning Date

If aid is not authorized in accord with the W&IC and regulations governing the beginning date and underpayment occurs on a new case, a restoration, an inter-county transfer, or a transfer between ANB-APSB, and OAS such underpayment is to be adjusted provided the amount due can be authorized before the end of the fourteenth month following the month in which aid was to have begun.

ADJUSTMENT BY THE APPEAL PROCESS

Underpayment (regardless of cause) shall be adjusted by authorization of aid in the amount and for the period ordered by the SSWB or agreed to by the SDSW (see Secs. 055.3 and 055.4).

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(Pursuant to Government Code Section 11380.1)

C-319

SERVICES TO CHILDREN AND THEIR PARENTS AND FOSTER PARENTS WHEN A
CHILD HAS BEEN REMOVED FROM HIS HOME BY COURT DETERMINATION

C-319

When a child receiving Aid to Needy Children in a family group has been removed, after April 30, 1961, from his home by a court who has found that it is contrary to the welfare of the child to continue living there, and the court has designated the county welfare department as the agency responsible for the child's placement, care and supervision in a foster home, Federal participation is available in the aid payment. The responsibilities of the county welfare department are:

1. To develop a plan for the care of the child in a foster home.
2. To place the child in a foster home and provide supervision to assure proper care.
3. To provide for periodic review of the necessity for the child remaining in foster care.
4. To provide for services to improve conditions in his home so that he may return there, or to make possible his placement in the home of another relative (i.e., family counseling, individual casework services, group counseling, health services).
5. To determine that aid was received in and for the month in which action was initiated by an authoritative agency in removal of the child because of imminent danger to the safety of the child, or the filing of the petition, whichever was earlier.
6. To provide reports to the court as required, or as indicated by the case development.
7. To use professionally qualified ANC and Child Welfare staff to the maximum extent practical in the placement service for the child.

(See Fiscal Manual Sections F-525 and F-730)

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CONTINUATION SHEET
F FILING ADMINISTRATIVE REGULATIONS
WITH THE SECRETARY OF STATE
(Pursuant to Government Code Section 11380.1)

Regulations

AID PAYMENTS

C-227.60

C-227.60 ADJUSTMENT OF UNDERPAYMENT BY AUTHORIZATION OF RETROACTIVE AID C-227.60

Definition

Retroactive aid is aid authorized in a subsequent month for some preceding month or months.

Adjustment by County Administrative Action

Underpayment is adjusted by administrative action authorizing payment of retroactive aid under the circumstances prescribed below and within the time limits specified.

1. Underpayment resulting from an administrative error or inadvertence.
(See Sec. C-227.51.)

Such underpayment (including underpayment resulting from a denial or discontinuance due to administrative error or inadvertence) is to be adjusted as provided in W&IC Sec. 103.3, Item f.

2. Underpayment resulting from other causes

Underpayment resulting from causes other than "administrative error or inadvertence" is to be adjusted in accord with whichever of the following circumstances is appropriate:

- a. Recipient Eligible to a Larger Grant than that Authorized

When aid is paid in the amount authorized but it is later determined that the recipient was eligible for a greater amount (as determined in accord with Sec. C-221), the underpayment is to be adjusted, provided the additional amount due can be authorized before the end of the 14th month following the month for which the recipient was underpaid.

(Continued)

CONTINUATION SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
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(Pursuant to Government Code Section 11380.1)

C-227.60

AID PAYMENTS

Regulations

C-227.60 (Continued)

C-227.60

b. Aid Denied or Discontinued to an Eligible Person

When, within 12 months after date of applicant's or recipient's notification of a denial or discontinuance, the county obtains additional information which indicates eligibility existed for the denied or discontinued payments, the underpayment is to be adjusted provided:

- (1) The applicant or recipient met his responsibility for reporting promptly all facts required of him pursuant to W&IC Section 103.3, Item b; and
- (2) The retroactive aid can be authorized before the end of the 14th month following that in which the discontinuance or denial action occurred.

(The authorization is to be in the amount to which the person was eligible and for the period during which he would have received aid if such aid had been granted or continued instead of denied or discontinued.)

c. Incorrect Beginning Date

When aid is not authorized in accord with the code and regulations governing the beginning date, and underpayment occurs on a new case, a restoration, or an intercounty transfer, such underpayment is to be adjusted provided the amount due can be authorized before the end of the 14th month following the month in which aid was to have begun.

Adjustment by the Appeal Process

Underpayment (regardless of cause) shall be adjusted by authorization of aid in the amount and for the period ordered by the SSWB or agreed to by the SDSW (see Secs. 055.3 and 055.4).

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D-025

RECORDS, FORMS AND CONTROLS

Regulations

D-025

REQUIRED FORMS FOR WHICH SUBSTITUTE MAY BE USED

D-025

The following forms are required to be completed for the purposes indicated in the instructions for their use, except that the county may use a substitute form which provides substantially the same information.

DA 4	Transmittal of ATD Reports
DA 158	Aid to the Needy Disabled - Budget Work Sheet (See Sec. D-201)
DA 158 FMI	Budget Work Sheet - ATD - Public Medical Institution
DA 206	Recipient's Affirmation of Eligibility for Aid to the Needy Disabled (See Secs. D-015.20 and D-015.30)
DA 239	Notice of Action - Aid to the Needy Disabled (See Sec. D-014.70)
DA 239 C	Important Notice to all Recipients of Aid to the Needy Disabled .
ABCD 239	Notice of Action
ABD 228	Authorization for Financial Investigation (See Sec. D-012.40)
ABD 231	Certificate of Delivery of Payment of Aid (See Sec. D-141.50)
ABD 236A	Certification of Patient Status in a Public Medical Institution (See Sec. D-141.40)
	and/or
ABD 236B	Certification of Patient status in a Public Medical Institution (See Sec. D-141.40)
ABD 278L*	List of Authorizations to Start, Change, Stop or Deny Aid Payments (See Sec. D-221)
ABD 278M*	Authorization to Start, Change or Stop Aid Payments (Action Card)
DA 280*	Identification Card (See Sec. D-014.80)
DPA 5	Summary Letters of Guardianship or Conservatorship (See Sec. D-011.12, etc.)
DPA 8	Notice to Applicant who Withdraws Application (See Sec. D-014.70)

* Use of substitute Forms ABD 278L, ABD 278M and DA 280 requires prior SDSW approval.

CALIFORNIA-SDSW-MANUAL- ATD

Rev. 471 replaces Rev. 421

Effective 9/1/61

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CONTINUATION SHEET
**F FILING ADMINISTRATIVE REGULATIONS
 WITH THE SECRETARY OF STATE**
 (Pursuant to Government Code Section 11380.1)

D-179 APPEALS BASED ON DISABILITY

D-179

An individual who is dissatisfied with the disability determination has the right to appeal for a fair hearing. If the appellant has not been examined by a medical specialist (Board Certified or Board eligible) in the area of the appellant's major disability within three months of the day the appeal is filed, the county shall refer the appellant to such a specialist immediately after notification from SDSW that the appeal has been filed and shall submit the specialist's report at least ten days before the hearing.

The report of the examination by the specialist shall be submitted to the appropriate Area Office and assigned for evaluation to a Review Team other than the one which made the disability determination being appealed. If, on the basis of the additional medical evidence and any other information submitted by the county, this Review Team finds that the case can be approved on the disability factor it will issue a new Certificate of Disability, DA 3. Aid can be granted or restored without the formality of a hearing by the SSWB if the appellant is otherwise eligible as provided in Section D-223.

The appellant may submit additional medical reports to support his appeal at the time of the hearing. Any expense for reports not required by the SDSW is the responsibility of the appellant.

D-203 SPECIAL NEEDS NOT COMMON TO ALL RECIPIENTS

D-203

Special needs are those which are not common to all recipients and which arise out of physical infirmities or other conditions peculiar to the individual's circumstances. In ATD, the only allowable special need is attendant service. The service must be provided by someone other than a relative with whom the recipient lives. Payment for attendant services is not allowable to persons in public and private medical institutions, nursing homes, aged institutions licensed by SDSW and facilities licensed by the State Department of Mental Hygiene.

D-204.47 MAXIMUM ALLOWANCES FOR ATTENDANT SERVICES

D-204.47

(See Sec. D-212.40 for regulations governing income.)

ATD recipients may be allowed up to a maximum of \$150 per month for attendant care.

In exceptional cases and under specified circumstances (See Handbook Section D-204.47), a total allowance for attendant care of as much as \$300 per month may be approved. Allowance in excess of \$150 per month may be made only upon prior authorization of the SDSW.

The cost of attendant care includes expenses incidental to employment such as carfare, meals, Social Security deductions, etc.

Allowances for attendant care shall be in accordance with the rate prevailing in the local community. The rate may be less in individual situations.

When the recipient lives with an unrelated caretaker and board and care is budgeted according to the Institutional Table of Allowances, the maximum additional amount payable to the caretaker for attendant services is \$60. (See Handbook Section D-204.47.)

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D-202 DETERMINATION OF NEED Regulations

D-202 ALLOWABLE NEEDS COMMON TO ALL RECIPIENTS D-202

The following allowable items of need are considered common to all recipients and are to be provided unless otherwise specified:

ATD - Standard of Assistance

Basic Need	Noninstitutional Table of Allowances (Living alone, sharing household or room and board)
Food	\$ 29.00
Housing and Utilities	as paid to maximum of \$30
Household maintenance	6.00
Medicine chest supplies	1.50
Telephone service	1.50
Clothing	8.00
Personal care and incidentals	7.50
Education and recreation	7.50
Services related to disability	15.00
Total exclusive of Housing and Utilities	\$ 76.00*

*Basic allowance is \$76 plus cost of housing and utilities as paid to a maximum of \$30. On a Room and Board basis, allow for room and meals as paid to maximum of \$65 plus \$41 for other allowable items of need.

Basic Need	Institutional Table of Allowances or Board and Care basis*
Board and care	\$ 90.00 maximum allowable
Personal and incidental needs allowance	16.00
	\$106.00

*May be used when recipient lives with an unrelated caretaker and receives personal care and services on a Board and Care basis. (Also see Sec. D-204.47.) For persons in public medical institutions beyond a temporary period, part or all of grant is paid directly to the institution as a vendor payment (see Sec. D-225).

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Regulations

DETERMINATION OF NEED

D-204.45

D-204.45 EVALUATING THE NEED FOR ATTENDANT SERVICES

D-204.45

In evaluating the need of ATD recipients for attendant services, the following factors shall be considered:

1. Whether residence in the home will help to maintain integrity of the family unit.
2. Whether residence in the home is physically and psychosocially preferable to institutionalization.
3. Whether human dignity and decency can be enhanced through attendant service.
4. Whether persons with a short life expectancy can be afforded the comfort of family life.

ATD recipients to be considered for attendant services generally fall within one or more of the following groups:

1. Bedfast, chairbound or helpless persons for whom institutional care is not indicated because of family ties or other personal consideration and whose relatives can provide needed care if they have some assistance from an attendant.
2. Recipients whose care results in neglect of children, family strain or an excessive burden upon the major caretaker due to the latter's responsibility for other disabled persons, small children, employment outside the home, or other substantial duties.
3. Recipients dependent for care upon an aged, ill or unrelated person; or who are themselves responsible for the care of minor children or an aged or disabled person.
4. Recipients living alone and dependent upon relatives, neighbors, friends and/or tradespeople for essential services, or who are performing them themselves to the detriment of their health, or performing them in a substandard manner.
5. Mentally retarded and other recipients who require constant supervision and whose major caretaker needs relief from outside the family because of lack of other relatives willing and able to share the responsibility.
6. Recipients whose caretaker could secure employment and whose normal role is that of breadwinner.

Applicants or recipients eligible for OAS or ANB are ineligible for attendant services.

CALIFORNIA-SDSW-MANUAL- ATD

Rev. 478 replaces Rev. 446

Effective 9/1/61

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Regulations DETERMINATION OF INCOME D-212.51

D-212.40 EVALUATION OF INCOME IN KIND D-212.40

Income in kind is any benefit received other than in cash.

If a need item is being earned or contributed in kind, either directly or by payment to a vendor, the income value placed upon such earnings or contribution is the amount specified for the item in the standard of assistance for basic needs (see Chapter 20).

Since no amount is specified in the standard for housing and utilities, the following apply:

1. If both housing and utilities are earned or contributed, the item is not considered in computing need and no income is shown.
2. If either housing or utilities (or a part of these) is earned or contributed, determine need for both items by adding the actual share of housing plus a maximum of \$5 for utilities, and allow up to \$30. Then deduct as income either:
 - a. The recipient's share of housing or
 - b. \$5 if all necessary utility items are earned or contributed. If less than all items are earned or contributed, deduct the proportionate share of this figure, which is reasonably applicable to the items and which is the same figure as was used to compute need.

If the recipient's income specifically designated for attendant care, whether paid to a vendor or to the recipient, is sufficient to meet the allowable attendant care need, neither the need nor the income are considered in determining the grant to which eligible.

D-227.20 RIGHT TO DEMAND REPAYMENT D-227.20

The right exists to demand repayment in the amount which is unadjusted or unadjustable in the adjustment period if overpayment is due to failure of the recipient to report facts, unless he had no knowledge of the facts or was misinformed or not informed of his responsibility to report. (See Appendix Fiscal Manual Sections, Sec. F-410, Demand for Repayment.)

When aid is discontinued at the end of the month in which the recipient became ineligible to any grant, right to demand repayment of any overpayment in that month does not exist.

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Regulations

AID PAYMENTS

D-227.60

D-227.60 ADJUSTMENT OF UNDERPAYMENT BY AUTHORIZATION OF RETROACTIVE AID • D-227.60

Definition

Retroactive aid is aid authorized in a subsequent month for some preceding month or months.

Adjustment by County Administrative Action

Underpayment is adjusted by administrative action authorizing payment of retroactive aid under the circumstances prescribed below and within the time limit specified.

1. Underpayment resulting from an administrative error or inadvertence
(See Sec. D-227.51)

Such underpayment (including underpayment resulting from a denial or discontinuance due to administrative error or inadvertence is to be adjusted as provided in W&IC Sec. 103.3, Item (f).

2. Underpayment resulting from other causes

Underpayment resulting from causes other than "administrative error or inadvertence" or from "erroneous denial" is to be adjusted in accord with whichever of the following circumstances is appropriate:

- a. Recipient Eligible to a Larger Grant than that Authorized

When aid is paid in the amount authorized but it is later determined that the recipient was eligible for a greater amount (as determined in accord with Section D-221), the underpayment is to be adjusted provided the additional amount due can be authorized before the end of the 14th month following the month for which the recipient was underpaid.

Underpayment of \$2 or less for a particular month is adjusted only when a necessary increase of \$2 or less in the continuing grant (see Sec. D-226, Changes in Amount of Payment) was not made effective until after the second month following that in which the changed circumstances were reported. Payment of retroactive aid in such circumstances shall begin with such second month.

(Continued)

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D-227.60

AID PAYMENTS

Regulations

D-227.60 (Continued)

D-227.60

b. Aid Denied or Discontinued to an Eligible Person

When, within 12 months after date of applicant's or recipient's notification of a denial or discontinuance, the county obtains additional information which indicates eligibility existed for the denied or discontinued payments, the underpayment is to be adjusted provided:

- (1) The applicant or recipient met his responsibility for reporting promptly all facts required of him pursuant to W&IC Sec. 103.3, Item (b) and
- (2) The retroactive aid can be authorized before the end of the 14th month following that in which the discontinuance or denial action occurred.

(The authorization is to be in the amount to which the person was eligible and for the period during which he would have received aid if such aid had been granted or continued instead of denied or discontinued.)

c. Incorrect Beginning Date

When aid is not authorized in accord with the code and regulations governing the beginning date, and underpayment occurs on a new case, a restoration or an intercounty transfer, such underpayment is to be adjusted provided the amount due can be authorized before the end of the 14th month following the month in which aid was to have begun.

Adjustment by the Appeal Process

Underpayment (regardless of cause) shall be adjusted by authorization of aid in the amount and for the period ordered by the SSWB or agreed to by the SDSW (see Secs. 055.3 and 055.4).

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052.4 TIME LIMIT ON APPEALS

052.4

An appeal may not be filed more than one year after the order or action with which the applicant or recipient is dissatisfied. The date on which the appeal is first received in any office of the State Department of Social Welfare shall be considered the filing date.

The date of the order or action from which the appeal is taken shall be the date on which notice of such order or action was mailed to the appellant with the following exceptions:

1. In appeals for the return of erroneous repayments the date of collection or the date of the last installment payment is the determining date.
2. In appeals concerning the amount of the grant, the appeal must be filed within one year, but the period of review will extend back to the first day of the month in which the first day of the one year period occurred.
3. If the last day of the one year period falls on a Saturday, Sunday or holiday, the appeal may be filed on the next business day.

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CALIFORNIA-SDSW-MANUAL

Issue No. 05-14 (Rev. 4)

Effective 9/15/61

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The following Department Bulletins are repealed effective September 1, 1961:

- 538 (Merit System) Revision to Class Specifications for the Intermediate Level Clerical Classes
- 578 (Stat) Special Report on Needs, Income, and Expenditures for Drugs for June 1959
- 585 (Stat) Transfer Rate Sample Study County Medical Care Revolving Funds
- 587 (Stat) Transfer Rate Sample Study County Medical Care Revolving Funds
- 591-B (MC) Dental Care to OAS Recipients Added as Medical Care Fund Service Effective November 1, 1960
- 593 (MC) Nursing Services to Include Public Agency Nurses Effective November 1, 1960
- 596 (OAS, AB, ATD, MC) Notices to Recipients Regarding Medical Care Program
- 601 (Stat) Monthly Statistical Report on Medical Care for Aid to Needy Disabled Recipients, Form DA 260
- 603 (Stat) Reporting Persons for Whom Medical Care Payments Are Made After Eligibility Terminated, OAS, ANB, ATD, ANC-FG

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(Pursuant to Government Code Section 11380.1)

POLICY RESOLUTION

State Social Welfare Board

WHEREAS the purpose of Aid to Needy Children as defined by law is to provide aid to needy children deprived of parental support or care, and

WHEREAS the State Social Welfare Board believes that it is the object of this law to allow the children opportunities to grow and develop in a secure and healthful environment in spite of circumstances of need and/or neglect as evidenced among other things, by parental desertion, separation or abandonment, and

WHEREAS this Board believes that the quality of example, care, guidance and action provided by the parent or parents is important as well as the financial assistance in affording the child an opportunity to develop in a secure and healthful environment, and

WHEREAS, information coming to the attention of this Board from other sources as well as in the testimony given in many appeals indicates that the granting of assistance may be instrumental in some cases in keeping children in homes under conditions of parental supervision that might otherwise have long since come to the attention of juvenile authorities as cases of neglect or abuse, and

WHEREAS this Board believes that the granting of assistance should be to augment rather than to supplant the community's concern and protection for the total well being of those children, and

WHEREAS this Board believes there is a direct relationship in many instances between the economic circumstances of the family, the quality of parental guidance and supervision and the behavior of the parental figure, and

WHEREAS the Board accepts the principle that while alternate plans for some of these children are needed it does not condone the denial of aid to children in need while they are left in the unsatisfactory home.

WHEREAS this Board believes that the relationships involved in the granting of public aid to a family provides a compatible and unique opportunity for extending simultaneously positive help, guidance and direction through parents which should be utilized to the fullest as a voluntary means before utilizing other civil and criminal proceedings;

THEREFORE BE IT RESOLVED, that it is the policy of this Board that the administration of Aid to Needy Children by the public welfare departments of the counties should be conducted so as:

These Regulations are designated to become effective SEP 1 1961

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(Pursuant to Government Code Section 11380.1)

1. To assure evaluation of and concern with the home conditions under which the children are living, including parental ability to provide consistent, positive guidance and control. Of particular concern should be those situations in which there is failure to use opportunities available to them, children are maintained under grossly inadequate conditions, or children are exposed to parental behavior or guidance which is destructive, degrading, or detrimental to their development.
2. To offer specific action through appropriate welfare services in situations which are indicated above, and
3. To provide for and encourage referral to judicial and law enforcement officials of those situations which indicate that sound provisions for the protection and care of the children require judicial intervention, and

BE IT FURTHER RESOLVED that even though children are living under inadequate conditions, aid will be continued so long as children are in need and no alternative is provided, and

BE IT FURTHER RESOLVED that the State Department of Social Welfare will with the cooperation of appropriate personnel from county welfare departments, Juvenile Courts and other agencies:

1. To develop proposed regulations, standards, and procedures to give effect to the above policies including criteria and procedures for selection and referring of cases requiring judicial attention, and
2. To develop and carry forward specific training activities in cooperation with county welfare departments designed to assist local staff in carrying out functions relating to this policy.

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These Regulations are designated to become effective SEP 1 1961